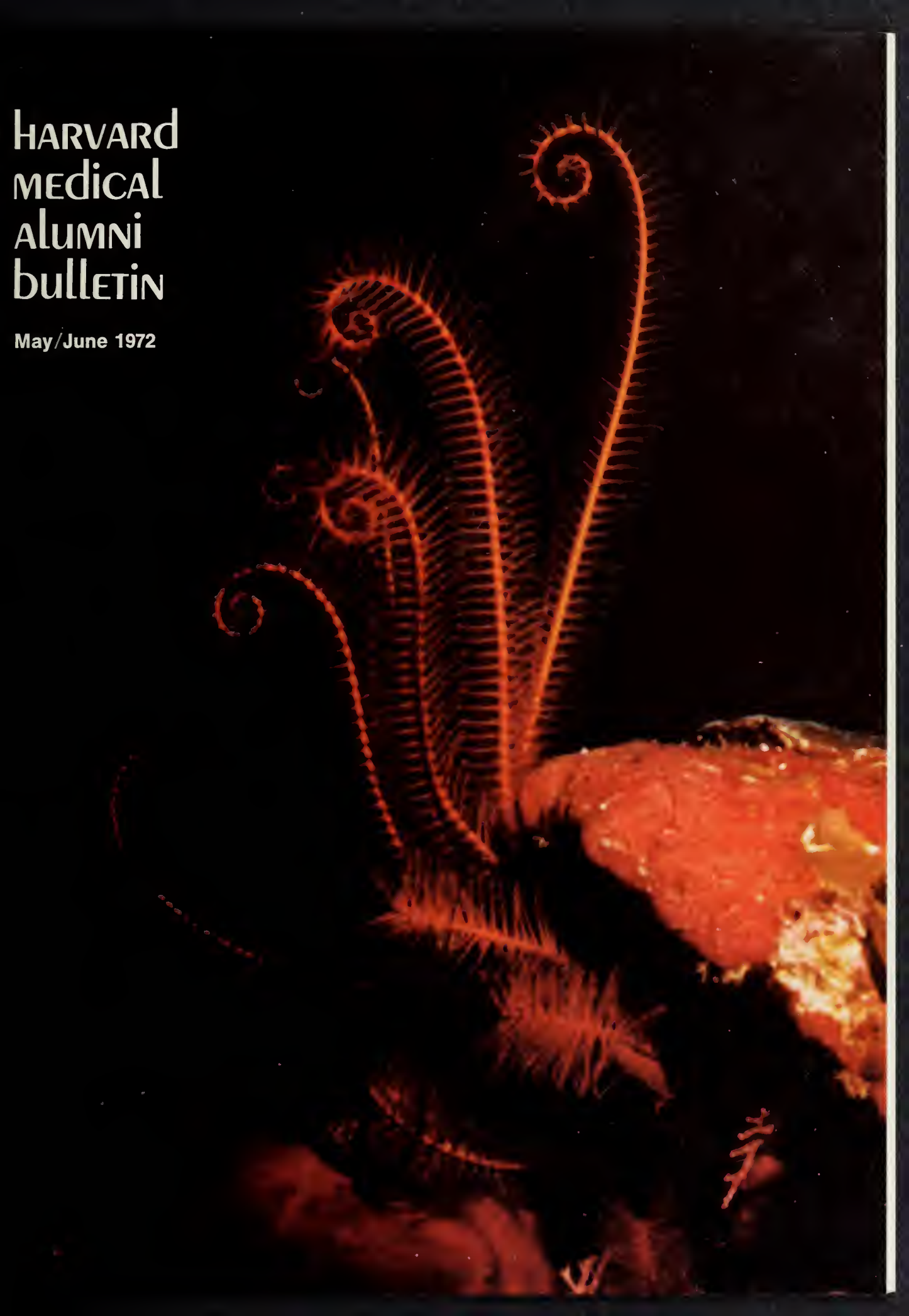
HARVARD MEDICAL ALUMNI BULLETIN

May/June 1972




The negative power of undue anxiety
in congestive heart failure...
This man thinks he can no longer
take breathing for granted.

Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

Aid in rehabilitation

Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

Concomitant use with primary agents

Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

The positive power of

Libritabs®
(chlordiazepoxide)

5-mg, 10-mg, 25-mg tablets

t.i.d./q.i.d.

up to 100 mg daily

for severe anxiety accompanying congestive heart failure

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SPECIAL REDUCED RATES FOR HARVARD ALUMNI

EIGHTH ANNUAL TOUR PROGRAM—1972

This unique program of tours is offered to alumni of Harvard, Yale, Princeton, M.I.T., Cornell, Dartmouth, Univ. of Pennsylvania and certain other distinguished universities and to members of their families. The tours are based on special reduced air fares which offer savings of hundreds of dollars on air travel. These special fares, which apply to regular jet flights of the major scheduled airlines but which are usually available only to groups and in conjunction with a qualified tour, are as much as $500 less than the regular air fare. Special rates have also been obtained from hotels and sightseeing companies.

The tour program covers areas where those who might otherwise prefer to travel independently will find it advantageous to travel with a group. The itineraries have been carefully constructed to combine the freedom of individual travel with the convenience and savings of group travel. There is an avoidance of regimentation and an emphasis on leisure time, while a comprehensive program of sightseeing ensures a visit to all major points of interest. Hotel reservations are made as much as a year and a half in advance to ensure the finest in accommodations.

EAST AFRICA

22 DAYS $1699

A luxury "safari" to the great national parks and game reserves of Uganda, Kenya and Tanzania. The carefully planned itinerary offers an exciting combination of East Africa's spectacular wildlife and breathtaking natural scenery: great herds of elephant and a launch trip through hippo and crocodile in **MURCHISON FALLS NATIONAL PARK**; multitudes of lion and other plains game in the famed **SERENGETI PLAINS** and the **MASAI-MARA RESERVE**; the spectacular concentration of wildlife in the **NGORONGORO CRATER**; tree-climbing lions around the shores of **LAKE MANYARA**; the **AMBOSELI RESERVE**, where big game can be photographed against the towering backdrop of snow-clad Mt. Kilimanjaro; and the majestic wilds of **TSAVO PARK**, famed for its elephant and lion as well as its unusual Mzima Springs. Also included are a cruise on **LAKE VICTORIA** in Uganda and visits to the fascinating capital cities of **KAMPALA** and **NAIROBI**. The altitude in East Africa provides an unusually stimulating climate, with bright days and crisp evenings (frequently around a crackling log fire), and the tour follows a realistic pace which ensures a full appreciation of the attractions visited. Total cost is $1699 from New York. Optional extensions are available to the famed **VICTORIA FALLS**, on the mighty Zambezi River between Zambia and Rhodesia, and to the historical attractions of **ETHIOPIA**. Departures in January, February, March, May, June, July, August, September, October, November and December 1972 ($25 additional for departures in June, July, August).

THE ORIENT

30 DAYS $1759

1972 marks the eighth consecutive year of operation for this outstanding tour, which offers the greatest attractions of the Orient at a sensible and realistic pace. Twelve days are devoted to the beauty of **JAPAN**, visiting the ancient "classical" city of **KYOTO**, the modern capital of **TOKYO**, and the lovely **FUJI-HAKONE NATIONAL PARK**, with excursions to ancient **NARA**, the magnificent medieval shrine at **NIKKO**, and the giant Daibutsu at **KAMAKURA**. Visits are also made to **BANGKOK**, with its glittering temples and palaces; the fabled island of **BALI**, considered one of the most beautiful spots on earth; the ancient temples near **JOGJAKARTA** in central Java; the mountain-circled port of **HONG KONG**, with its free port shopping; and the cosmopolitan metropolis of **SINGAPORE**, known as the "cross-roads of the East." Tour dates include outstanding seasonal attractions in Japan, such as the spring cherry blossoms, the beautiful autumn leaves, and some of the greatest annual festivals in the Far East. Total cost is $1759 from **California**, $1965 from **Chicago**, and $2034 from **New York**, with special rates from other cities. Departures in March, April, June, July, September and October 1972.

AEGEAN ADVENTURE

22 DAYS $1329

This original itinerary explores in depth the magnificent scenic, cultural and historic attractions of Greece, the Aegean, and Asia Minor—not only the major cities but also the less accessible sites of ancient cities which have figured so prominently in the history of western civilization, complemented by a luxurious cruise to the beautiful islands of the Aegean Sea. Rarely has such an exciting collection of names and places been assembled in a single itinerary—the classical city of **ATHENS**; the Byzantine and Ottoman splendor of **ISTANBUL**; the site of the oracle at **DELPHI**; the sanctuary and stadium at **OLYMPIA**, where the Olympic Games were first begun; the palace of Agamemnon at **MYCENAE**; the ruins of ancient **TROY**; the citadel of **PERGAMUM**; the marble city of **EPHESUS**; the ruins of **SARDIS** in Lydia, where the royal mint of the wealthy Croesus has recently been unearthed; as well as **CORINTH**, **EPIDAUROS**, **IZMIR** (Smyrna) the **BOSPORUS** and **DARDENELLES**. The cruise through the beautiful waters of the Aegean will visit such famous islands as **CRETE** with the Palace of Knossos; **RHODES**, noted for its great Crusader castles; the windmills of picturesque **MYKONOS**; the sacred island of **DELOS**; and the charming islands of **PATMOS** and **HYDRA**. Total cost is $1329 from New York. Departures in April, May, July, August, September and October, 1972.

MOGHUL ADVENTURE

29 DAYS $1725

An unusual opportunity to view the outstanding attractions of India and the splendors of ancient Persia, together with the once-forbidden mountain kingdom of Nepal. Here is truly an exciting adventure: India's ancient mounuments in **DELHI**; the fabled beauty of **KASHMIR** amid the snow-clad Himalayas; the holy city of **BANARAS** on the sacred River Ganges; the exotic temples of **KHAJURAHO**; renowned **AGRA**, with the Taj Mahal and other celebrated monuments of the Moghul period such as the Agra Fort and the fabulous deserted city of Fatehpur Sikri; the walled "pink city" of **JAIPUR**, with an elephant ride at the Amber Fort; the unique and beautiful "lake city" of **UDAIPUR**; a thrilling flight into the Himalayas to **KATHMANDU**, capital of **NEPAL**, where ancient palaces and temples abound in a land still relatively untouched by modern civilization. In **PERSIA** (Iran), the visit will include the great 5th century B.C. capital of Darius and Xerxes at **PERSEPOLIS**; the fabled Persian Renaissance city of **ISFAHAN**, with its palaces, gardens, bazaar and famous tiled mosques; and the modern capital of **TEHERAN**. Outstanding accommodations include hotels that once were palaces of Maharajas. Total cost is $1725 from New York. Departures in January, February, August, October and November 1972.

Rates include Jet Air, Deluxe Hotels, Most Meals, Sightseeing, Transfers, Tips and Taxes. Individual brochures on each tour are available.

For Full Details Contact:

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One North Broadway
White Plains, N.Y. 10601

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COVER: S. Harold Reuter '59 a prize-winning underwater photographer and otorhinolaryngologist was awarded a gold medal for "Les Plumes" by the Underwater Society of America. For the feature story on Dr. Reuter, see page 35.

CREDITS: Cover and pp. 35-39, S. Harold Reuter; Christopher Morrow, pp. 7, 11-13; Belmont Photo, pp. 8; The Bettmann Archive, pp. 15-19; Ernest Kahn, pp. 26, 27; drawings by Ernest Craige '43A, pp. 28-30.

OVERVIEW

Diary of Dissent

On April 19, 1972 the Presidents of Harvard, Yale, Princeton, Pennsylvania, Columbia, Cornell, Dartmouth, Brown, and MIT released the following statement concerning the stepped up bombing in Indochina:

> Although none of us can speak for his institution, all of us personally oppose a national policy which seems to be based on the belief that the United States must at almost any cost win the war in which it is engaged in Indochina. The costs of such a policy in human life and suffering are appalling and unjustified. We therefore deplore the bombing of North Vietnam and its civilian population. America's withdrawal from this brutal war would represent a recognition that this country can overcome past mistakes, for which many must assume the blame, and would open possibilities for conciliation that continued hostilities and bombing never can provide. We believe full disengagement should be pressed and oppose the continuation of the air war for any purpose other than the immediate protection of U.S. troops in the process of withdrawal.
>
> All of us feel deeply the need for Americans of all ages to find nonviolent, constructive outlets for the expression of their views, their distress, and their concerns. We support activities to this end as long as they are not at the expense of the rights of others or at the expense of the continuation of constructive, educational, and scholarly activity of universities and colleges. We therefore support the efforts of those who work in behalf of candidates sympathetic to their views or communicate their feelings to appropriate government officials. We do not condone coercive action by individuals or groups seeking to impose their particular convictions or concerns on others.

Friday morning, April 21, 1972, Dean Robert H. Ebert issued a statement to the press that reads as follows:

> Once again, for the third time in four years, we are finding it necessary to divert our concerns for the education of those who will be the health leaders of the future, to protest against the continuance of a needless conflict in Indochina.
>
> Though I cannot speak for the Faculty of Medicine at Harvard, as a citizen, a physician, and as an educator, I deeply regret that the energies of our medical students, as well as the energies of students across the nation, must again be expended in an effort to focus national attention on their utter abhorrence of the continued slaughter of citizens in Indochina.
>
> How much more fruitful it would be if the energies of our medical and dental students could be directed, as increasingly they indeed have been, toward the health needs and the welfare of our citizens as well as those in foreign nations.

Addressing himself to the decision of the first year class to call a strike Dean Ebert said:

> We respect the rights of those who have voted to strike as well as those who cast their votes in opposition. Many of the latter have made clear that they do not consider a strike as the most appropriate expression of their personal view, even though they do not support the Southeast Asian conflict. Thus, based on decisions made in similar situations in the past, the Medical School will not suspend any scheduled classes or activities on Friday, April 21. Instructors, however, may choose to schedule their classes at a later date, if they so desire. At the same time we expect that those students who wish to attend classes that are not suspended, shall be able to do so.

In their statement issued to the press, the first year class announced:

> The first year classes of Harvard Medical School and Harvard School of Dental Medicine have voted to postpone classes on Friday, April 21 to participate in the national moratorium protesting the policy of the American government in Vietnam. We are demonstrating our opposition to a war which is unjust, immoral and a violation of the goals of our medical education. We join with others across the nation in demanding an immediate end to all U.S. military involvement in Southeast Asia.

A rally was held on the Quadrangle at 11:30 Friday, April 21, sponsored by the first year classes of the Medical and Dental School. First to speak to the assemblage of approximately 100 people was Leon Assael, HSDM. Mr. Assael in his speech, quoted Thomas Paine: "These are the times that try men's souls. The summer soldier and the sunshine patriot will, in this crisis, shrink from the service of his country; but he that stands it *now*, deserves the love and thanks of man and woman. Tyranny, like hell, is not easily conquered." Mr. Assael announced that the students would march to the Boston Common, where they would join students from other schools, also protesting the war.

Second on the podium was Dr. Frederick C. Lane, Dean of Students. Dr. Lane read Dr. Ebert's statement, and voiced his agreement with it. He urged the students to contact the Dean's office, should they encounter any difficulty on the march they were about to begin.

Next to speak was Dr. Leon Eisenberg, professor of psychiatry and head of the department of psychiatry at Massachusetts General Hospital. Dr. Eisenberg said: "War is the most malignant of diseases,

therefore it is most appropriate for physicians to engage in social protest." He concurred with the actions of the students and joined them in their march to the Boston Common.

The marchers from the Medical School joined students from other campuses in the area and walked to the Common. From the Common, the demonstration moved, en masse, to Post Office Square, where a rally was held. The demonstration broke up shortly thereafter, with no incidents reported.

Crosses were planted in the Quadrangle at Harvard Medical School on May 4 as part of a Moratorium to protest the war in Indochina. Sponsored jointly by the Medical Area Peace Action Group, the Harvard Medical School Faculty Committee, and the Harvard Medical Pre-Clinical Council, the day's activities were highlighted by a slide show, "The Electronic Battlefield" supplied by the American Friends Service Council. Also included in the Moratorium were discussions of medical aid for IndoChina, future peace actions, and support of peace candidates.

Two resolutions critical of the escalation of the air war in both North and South Vietnam and the naval blockade of North Vietnamese ports by the armed forces of the United States were favored at a meeting of more than 200 members of the Faculty of Medicine, HMS students, and members of the staff, held on May 15.

The resolutions were voted at an open meeting that had been called by Dean Robert H. Ebert, in response to a petition by a group of faculty members.

The resolutions and the vote on each follow:

RESOLUTION I: Drafted by an *ad hoc* group of the Faculty of Medicine, Harvard University.

VOTE: 214 Favored
3 Opposed

We affirm our continuing opposition to the war in Indochina. We deplore the recent American naval blockade of North Vietnam and massive bombing of Indochina, and the accompanying unjustifiable suffering of an innocent population. We urge the President to withdraw immediately *all* American military forces from Southeast Asia, and the Congress to cut off all military funds for this undeclared war.

We urge all members of the Harvard Medical School community to participate in anti-war activities in Boston and Washington as compelled by the dictates of conscience, and provided that there is no disruption of essential medical services.

It is imperative to dissociate ourselves from the war policies of our present government. Therefore we urge contribution to efforts to send medical supplies to all Indochinese peoples, including those living in areas not controlled by U.S. supported forces.

RESOLUTION II: Endorsed by the Medical Area Political Action Group.

VOTE: 174 Favored
15 Opposed
23 Abstained

For well over ten years, we have paid with our taxes to have popular movements in Indochina suppressed. The U.S. government has used our money to kill, starve, and maim millions of Asian men, women, and children, and to drive 1/3 of the South Vietnamese and Laotians from their homes, to make the countryside unliveable, and to waste the lives of 50,000 Americans in the process. All this it has done without a declaration of war, without a vote of the American people, and, in fact, over the increasing and open opposition of the majority.

In the past we have voted against the war, marched against it, demonstrated against it, and withheld our taxes from it, and the war continues.

We affirm once more our repudiation of American imperialism in Southwest Asia. But we want now to go beyond earlier types of protest. As a first step we express our support for the Provisional Revolutionary Government of South Vietnam as the best alternative to the present military dictatorship in the South. We now affirm this stand by contributing one day's pay, or a portion thereof, to Medical Aid for Indochina, Inc., which will deliver on our behalf funds for medical supplies and reconstruction to the PRG of South Vietnam, the Pathet Lao, and the Democratic Republic of Vietnam.

Any Alumnus wishing to endorse either of the petitions or to contribute to Medical Aid for Indochina, Inc. may do so by sending his name or donation to Harvard Medical School in care of the Information Desk at Vanderbilt Hall.

Hiatt Takes Helm of HSPH

Howard H. Hiatt '48, Herrman L. Blumgart Professor of Medicine at Harvard Medical School and physician-in-chief at Beth Israel Hospital, will become Dean of the Harvard School of Public Health in July.

In announcing the Hiatt appointment, President Derek C. Bok said: "Dr. Hiatt is a proven administrator and a distinguished clinician and research scholar. To these abilities he has also added a keen interest in problems of community health and health care delivery. The growing importance of other traditional public health fields, will demand much of the School in years ahead. Howard Hiatt's intelligence, talent, and capacity promise the vigorous leadership that is needed."

Dr. Hiatt sees the problems of health care centered in the public health field, including delivery of health services. In a recent article in the *New England Journal of Medicine,* he described "Medical Care for Northbridge: A Model for Teaching Hospital-Community Interaction."

A distinguished researcher in normal and abnormal cellular growth, Dr. Hiatt has focused his research on applying new knowledge to understanding and managing cancer in man. In his studies, he worked with two Nobel laureates, James D. Watson of Harvard, Jacques Monod of the Pasteur Institute in Paris, and the virologist, Michael Stoker at the Imperial Cancer Research Unit in London.

Dr. Hiatt has been associated with Harvard since 1955 when he became instructor in medicine, and at the same time, began his work at Beth Israel Hospital. In 1963 Dr. Hiatt was named the Herrman L. Blumgart Professor of Medicine and physician-in-chief. Since 1964 he has also been a consultant in medicine to the Peter Bent Brigham Hospital and the Children's Hospital, as well as visiting consultant to the Imperial Cancer Research Unit in London.

In addition to his research and practice as physician-in-chief, Dr. Hiatt teaches, is chairman of the Research Career Program Committee at the National Institute of Arthritis and Metabolic Disease, and a member of the Community Health Services Committee of the Board of Trustees, Boston Department of Health and Hospitals. He has served on editorial boards of *Experimental and Molecular Pathology,* of *Human Pathology,* and of the American Society for Clinical Investigation.

As Dean of the School of Public Health, he succeeds John C. Snyder '35.

Dr. Hiatt

Dean Praises Diligence of Class Agents

The first annual dinner to honor the Class Agents of the Harvard Medical School Alumni was held at the Harvard Club on May 11, 1972. Recognition for the tireless and devoted efforts of these hard-working and unsung heroes of the Harvard Medical Alumni Fund was long overdue, according to Perry J. Culver '41, Director of the Alumni Association.

Dean Ebert expressed his personal gratitude to the Agents and stimulated a wide-ranging discussion which elicited many helpful comments about the affairs of the School from those present. The Dean emphasized the major role of the Alumni in preserving the future excellence of private institutions, such as HMS. He pointed out that the annual giving of the Alumni had a significant impact both in providing an important addition to the limited unrestricted funds so necessary for the development of new programs at the School, but even more importantly, foundations and other potential benefactors are much influenced by the support, or lack thereof, of the Alumni.

In honoring the Class Agents, the dinner amply fulfilled one of the important purposes of the Harvard Medical Alumni Association, namely, as stated in Article II of the Constitution, "to promote acquaintance and good fellowship among members of the Association."

The following Class Agents attended the dinner: Albert A. Hornor '11; Moses H. Lurie '17; Robert L. Goodale '23; James M. Baty '25; Richard Chute '27; Robert J. Joplin '28; Alfred O. Ludwig '30; Carl W. Walter '32; Bradford Cannon '33; Thomas A. Warthin '34; Irad B. Hardy, Jr. '38; Daniel S. Ellis '39; John W. Raker '41; Chester C. d'Autremont '44; J. Drennen Lowell '46; James M. Shannon '47; Philip Troen '48; Gerald S. Foster '51; William D. Cochran '52; Edwin L. Carter '53; Herbert J. Goldings '54; Roman W. DeSanctis '55; Robert M. Goldwyn '56; Richard A. Kingsbury '60; Clarence E. Zimmerman, II '61; Robert C. Moellering, Jr. '62; William D. Clark, II '65; Cary W. Akins '70; and Paul D. Walter '71.

New Dean of Students

Succeeding Joseph W. Gardella, who resigned as dean of students on March 17, is Frederick Carl Lane, M.D.

A native of Winston-Salem, North Carolina, Dr. Lane received the B.S. degree in 1960 from Davidson College and the M.D. degree in 1964 from Bowman Gray School of Medicine where he was a Babcock Scholar. He interned in surgery, did a general surgery residency, and was chief resident in surgery at the Peter Bent Brigham Hospital.

Dr. Lane

On completion of his residency training in 1970, Dr. Lane was a visiting scientist at the National Institute of Mental Research, Mill Hill, London. In 1971 he became a trainee in immunology in the laboratory of Dr. Baruj Benacerraf, George Fabyan Professor of Comparative Pathology. Dr. Lane's major interest is cellular immunology and he has been studying the interaction between lymphocytes and macrophages in the production of delayed hypersensitivity. In addition to his duties as dean of students, Dr. Lane will continue his work in the department of surgery at Peter Bent Brigham Hospital as a member of the transplant team and the cancer service.

Joseph W. Gardella resigned the deanship after serving the Medical School as assistant dean for student affairs from 1956-62, as associate dean of the faculty of medicine for student affairs from 1962-69, and as dean of students since 1969. Dr. Gardella will continue with the Medical School as a lecturer in medicine.

Dr. Gardella

Center Library Honors Schering Foundation

The Harvard Center for Community Health and Medical Care has received a gift of $150,000 from the Schering Foundation, Inc., payable in equal increments over a three-year period. The announcement was made jointly by Robert H. Ebert and Mr. W. H. Conzen, president of the Foundation. Dr. Ebert expressed thanks to the Schering Foundation and said that Harvard has approved the naming of the library at the Center as the Schering Foundation Library of Health Care.

Opened in the fall of 1969, the Library now consists of over 2,000 volumes and subscriptions to 80 journals. The materials are concerned with social and community medicine, paying particular attention to methodologies in planning and evaluation of health services, health manpower studies, utilization of health services by various population groups, economics, and cost and effectiveness studies of differing systems of health care delivery.

Under the direction of August La Rocco, Librarian, the staff engages in bibliographic research projects and has initiated a proposal to provide library service to neighborhood health centers in the city of Boston.

The Harvard Center for Community Health and Medical Care, headed by Paul M. Densen, Sc.D., was established in 1967 under the joint auspices of the Faculties of Medicine and Public Health at Harvard. The basic mission of the Center is to study and evaluate existing systems of health care, to develop data concerning the organization, financing, and distribution of health services, and to render assistance in the creation of new and reproducible models of health care.

Students host party honoring Dr. Gardella.

Cotran Named First Mallory Professor

The first Frank Burr Mallory Professor of Pathology in the Faculty of Medicine is Ramzi S. Cotran, M.D.

Dr. Cotran is associate director of the Mallory Institute of Pathology and visiting physician and head of the Harvard Pathology Unit at Boston City Hospital. His research involving inflammation, blood vessels, and kidney diseases with special reference to his initial interest in pyelonephritis has given him national and international renown.

Dr. Cotran

With his associates, Dr. Cotran devised an experimental system which, for the first time, demonstrated that a kidney infection could result from an ascending infection in the bladder. Further investigation involving immunoflourescence techniques provided evidence that bacterial antigens persisted in kidney tissue for long periods after the infection had disappeared. Other and current investigations carried on by Dr. Cotran and his colleagues are concerned with the mechanisms of the permeability of blood vessels during the body's response to inflammation as in burn injury, the pathophysiology of blood vessels, and mechanisms of protein loss in kidney diseases.

Dr. Cotran continues his investigations and also provides leadership to many students in the undergraduate teaching program at HMS, making significant contributions to the course in basic pathology.

Born in Haifa, Palestine, Dr. Cotran received his A.B. and M.D. degrees in 1952 and 1956 respectively from the American University of Beirut, Lebanon. He interned in pathology at the Mallory Institute of Pathology in 1956 and joined the teaching staff of HMS two years later. In 1966 he received a Research Career Development Award from the U.S. Public Health Service.

Among Dr. Cotran's professional organization memberships are the American Association for the Advancement of Science, American Association of Pathologists and Bacteriologists, American Society for Cell Biology, American Society of Nephrology, and the Association of University Professors of Pathology.

REMINISCENCES

The recent death of Dr. Chester Keefer was a sorrowful occasion. He was gentle, sensitive, and a medical scholar.

None of us who worked on the wards of the Fourth Medical Service of the Boston City Hospital will forget those days with Dr. Keefer in the early 1930's. When he was in attendance on either Wards T or U (later Peabody 1 and 2), all was carried out with proper decorum and style. The long ward had a dozen or so patients on each side, and we would proceed down one side and up the other three mornings a week. Promptly at 10:30 a.m. Dr. Keefer would appear; Miss Bemis, the head nurse, would close the door to the ward and pull the curtain. All was quiet; the patients were alerted; and the staff fell in line. Dr. Keefer then proceeded with medical clerks, staff, and nurses to the first patient. He listened quietly to the history and then quickly examined the patient. A few questions followed and then he proceeded to analyze "the case." He did so succinctly and with uncanny accuracy. He usually concluded with a brief recitation of the pertinent medical literature on the subject. I was a fortunate person to have had exposure to his knowledge and teaching for seven years!

One day we were half way down the male ward. As usual all was quiet, when an elderly Irishman across the way boomed out that he wanted a bedpan. He needed it urgently and banged his glass on the metal bedside table. Finally, all was quiet again. Mr. X, in desperation, had reached over to his table, pulled out the drawer containing his personal effects, and used it for a bedpan. In the meantime Miss Bemis had stepped out and brought a pan to him, but he bawled out that she was too late. One of the interns assisted Miss Bemis in retrieving the desk drawer and went out with her.

All through this uproar Dr. Keefer continued with his rounds, unruffled and paying not the slightest attention to the source of the noise. It was a superb display of Oslerian equanimity — Dr. Keefer was a Hopkins-trained man.

Subsequently, the intern entered a note in the patient's chart. "Mr. X complained of abdominal distress with a desire to have an evacuation. Not being aided promptly and after considerable commotion he used his table drawer as a bedpan. Gross examination of the contents revealed that Mr. X had passed a few copper and silver coins; rosary beads; and a deck of playing cards. He was relieved thereafter!"

Wesley W. Spink '32

HARVARD MEDICAL SCHOOL ANNOUNCES

The William O. Moseley, Jr. Travelling Fellowships

THE BEQUEST OF JULIA M. MOSELEY MAKES AVAILABLE FELLOWSHIP FUNDS FOR GRADUATES OF THE HARVARD MEDICAL SCHOOL FOR POSTDOCTORAL STUDY IN EUROPE.

The Committee on Fellowships in the Medical School has voted that the amounts awarded for stipend and travelling expenses will be determined by the specific needs of the individual.

In considering candidates for the Moseley Travelling Fellowships, the Committee will give preference to those Harvard Medical School graduates who have—

1. **Already demonstrated their ability to make original contributions to knowledge.**
2. **Planned a program of study which in the Committee's opinion will contribute significantly to their development as teachers and scholars.**
3. **Clearly plan to devote themselves to careers in academic medicine and the medical sciences.**

Individuals who have already attained Faculty rank at Harvard or elsewhere will not ordinarily be considered eligible for these awards.

There is no specific due date for the receipt of applications or for the beginning date of Awards except that the Committee requests that applications not be submitted more than 18 months in advance of the requested beginning date. The Committee will meet once a year in January to review all applications on file. Applicants will be notified of the decision of the Committee by January 31. The Committee may request candidates to present themselves for personal interviews.

Application forms may be obtained from, and completed applications should be returned to:

Secretary, Committee on Fellowships in the Medical School
Harvard Medical School
25 Shattuck Street, Boston, Massachusetts 02115

internship list

In general, all internships and residencies start July 1, 1972 for one year.

Name	*Hospital* (and location)	*Service*
Aldis, William L.	Baltimore City Hospital	Medicine
Anderson, Jeffrey L.	Massachusetts General Hospital	Medicine
Arkins, Thomas J.	Peter Bent Brigham Hospital	Surgery
Aspaas, Paul K.	Parkland Memorial Hospital, Dallas	Medicine
Bajart, Ann M.	The Cambridge Hospital, Cambridge	Rotating
Baller, Julie	San Francisco General Hospital	Medicine
Barrett, Steven A.	University of Colorado Affiliated Hospitals, Denver	Medicine
Beguin, Elaine D.	Yale-New Haven Medical Center	Medicine
Belin, Daniel C.	University of Michigan Affiliated Hospitals, Ann Arbor	Medicine
Berwick, Donald M.	Massachusetts General Hospital	Medicine
Billings, J. Andrew	San Francisco General Hospital	Medicine
Boger, Robert S.	University Hospitals, Madison, Wisconsin	Medicine
Borkowski, Henry	Bronx Municipal Hospital Center	Medicine
Boyd, John A.	Duke University Medical Center, Durham, North Carolina	Pediatrics
Brant, Rene S. T.	Massachusetts General Hospital	Pediatrics
Brem, Steven S.	Massachusetts General Hospital	Surgery
Brewer, David K.	Cleveland Metropolitan General Hospital	Medicine
Brown, Edward M.	Peter Bent Brigham Hospital	Medicine
Brush, Alan D.	Peter Bent Brigham Hospital	Medicine
Burns, David M.	Boston City Hospital (Harvard Service)	Medicine
Buzney, Sheldon M.	Children's Hospital Medical Center, Boston	Pediatrics
Cabot, Edmund B.	Peter Bent Brigham Hospital	Surgery
Candib, Lucy M.	The Cambridge Hospital	Rotating
Cantrill, Herbert L.	Barnes Hospital, St. Louis, Missouri	Medicine
Carrera, Guillermo F.	Peter Bent Brigham Hospital	Medicine
Casey, Alice E.	Los Angeles County Harbor General Hospital, Torrance	Pediatrics
Chambers, Susan L.	Peter Bent Brigham Hospital	Surgery
Chin, William W.	Beth Israel Hospital, Boston	Medicine
Clowes, Alexander W.	University Hospitals, Cleveland	Surgery
Cohen, Barry H.	Peter Bent Brigham Hospital	Medicine
Colgan, Joseph P.	Mayo Graduate School of Medicine, Rochester	Medicine
Come, Patricia A. C.	Beth Israel Hospital	Medicine
Come, Steven E.	Beth Israel Hospital	Medicine
Cowan, Douglas F.	Boston City Hospital (Harvard Service)	Medicine
Craig, William R.	Los Angeles County Harbor General Hospital	Medicine
Curfman, Gregory D.	Massachusetts General Hospital	Medicine
de Bruyn Kops, Julian	Jewish Hospital, St. Louis	Medicine
DeCesare, William F.	State University of Iowa Hospitals	Surgery
Desbiens, Norman A.	Boston City Hospital (Harvard Service)	Medicine
Diehl, Andrew K.	Los Angeles County Harbor General Hospital	Medicine
Dobkin, Jay F.	Montefiore Hospital and Medical Center, New York	Medicine
Drazen, Jeffrey M.	Peter Bent Brigham Hospital	Medicine
Eastman, Richard C.	Beth Israel Hospital	Medicine
Fineberg, Harvey V.	Beth Israel Hospital	Medicine
Fisher, Charles P.	Mount Zion Hospital, San Francisco	Rotating

Floyd, David A.	Harborview Medical Center, Seattle	Rotating
Frank, Kenneth D.	University of Michigan Affiliated Hospitals	Medicine
Frechette, David K.	Highland Hospital of Rochester, New York	Family Practice
Frederiksen, James W.	Peter Bent Brigham Hospital	Surgery
Freedman, Robert	Boston City Hospital (Harvard Service)	Medicine
Gage, Thomas P.	Strong Memorial Hospital, Rochester	Medicine
Garling, Andrew C.	Independent Study	
Gerber, Paul D.	University of California Hospitals	Medicine
Gessner, James S.	Duke University Medical Center	Pediatrics
Glass, Roger I.	The Cambridge Hospital	Rotating
Goldmann, David R.	Hospital of the University of Pennsylvania, Philadelphia	Medicine
Gonzalez, Jose R.	Massachusetts General Hospital	Surgery
Graves, Howard C.	San Francisco General Hospital	Medicine
Green, Laurence H.	Beth Israel Hospital	Medicine
Greiner, Paul T.	Rhode Island Hospital, Providence	Medicine
Grimes, Andrew M.	Boston City Hospital, (Harvard Service)	Surgery
Groves, James E.	Massachusetts General Hospital	*Psychiatry
Gruber, Gabriel G.	Boston City Hospital (Harvard Service)	Medicine
Hainen, Ronald L.	Strong Memorial Hospital	Rotating
Hamlin, Nason P.	Mary Hitchcock Memorial Hospital, Hanover, New Hampshire	Medicine
Hansbrough, John F.	University of Colorado Affiliated Hospitals	Surgery
Harley, William D.	University of Chicago Hospitals and Clinics	Medicine
Harmel, Richard P.	Massachusetts General Hospital	Surgery
Hedstrom, Peter S.	Boston City Hospital (Harvard Service)	Medicine
Hegg, Margaret E.	Stanford University Affiliated Hospitals	Medicine
Hegg, Stanley I.	Stanford University Affiliated Hospitals	Surgery
Herbert, Steven G.	The Cambridge Hospital	Rotating
Hertz, Kenneth C.	Boston City Hospital (Boston University Service)	Medicine
Hillier, Robert K.	Massachusetts General Hospital	Surgery
Hodge, Robert H.	University of Colorado Affiliated Hospitals	Medicine
Howley, Peter M.	Massachusetts General Hospital	Pathology
Jergesen, Harry E.	Massachusetts General Hospital	Surgery
Johnson, Mark F.	University of Utah Affiliated Hospitals, Salt Lake City	Medicine
Jones, Stuart A.	Mary Hitchcock Memorial Hospital	Medicine
Kay, Monte S.	McLean Hospital, Belmont	*Psychiatry
Kelling, Douglas G.	Duke University Medical Center	Medicine
Kemler, Barry J.	Hospital of the University of Pennsylvania	Medicine
Kirshner, Howard S.	Massachusetts General Hospital	Medicine
Kittredge, Diane	Yale-New Haven Medical Center	Pediatrics

Departing from tradition, the Internship Dinner was held at Anthony's Pier 4 instead of Vanderbilt Hall. The Alumni Association presented Kim Masters, permanent president of the Class of '72 (right) with a Harvard chair.

Left: Don W. Fawcett '42, Hersey Professor of Anatomy and featured speaker of the evening chats with students. Facing page, right: Maxwell Finland '26, president of the Alumni Association joins in the festivities; Left: President-elect John H. Talbot '28 and councilor Curtis Prout '41 discuss the evening's events.

Koepsell, Thomas D.	University of Washington Affiliated Hospitals	Medicine
Kohn, Martin S.	Montefiore Hospital and Medical Center	Medicine
Koopman, William J.	Massachusetts General Hospital	Medicine
Lange, Vladimir	Los Angeles County Harbor General Hospital	Surgery
Langley, Kim	Boston City Hospital (Boston University Service)	Pediatrics
Larkin, Andrew B.	Presbyterian-University of Pennsylvania Medical Center	Medicine
Lebwohl, Oscar	Mount Sinai Hospital, New York	Medicine
Leslie, Bruce R.	Massachusetts General Hospital	Medicine
Levitan, Charles T.	Michael Reese Hospital and Medical Center, Chicago	Medicine
Lewis, Lorenzo	San Francisco General Hospital	Rotating
Lieff, Jonathan D.	Boston State Hospital	*Psychiatry
Lipson, Stephen J.	Massachusetts General Hospital	Surgery
Lowe, Robert	Massachusetts General Hospital	Surgery
Lyman, Bruce T.	University of Minnesota Hospitals, Minneapolis	Medicine
Manders, Ernest K.	University of Michigan Affiliated Hospitals	Surgery
Marino, Joseph T.	Johns Hopkins Hospital, Baltimore	Pediatrics
Mason, Steven J.	Beth Israel Hospital	Medicine
Masters, Kim J.	William A. Shands Teaching Hospital and Clinics, Gainesville	Medicine
McCullough, Dennis M.	Swedish Hospital Medical Center, Seattle	Rotating
Mesulam, Marsel	Hospital of the University of Pennsylvania	Rotating
Meyer, Allen F.	University of Kentucky Medical Center, Lexington	Medicine
Michael, Max	University of Alabama Medical Center, Birmingham	Medicine
Monroe, Carl B.	Mount Sinai Hospital	Medicine
Morgan, G. James	University of Chicago Hospitals and Clinics	Medicine
Musliner, Thomas A.	Peter Bent Brigham Hospital	Medicine
Nathan, Carl F.	Massachusetts General Hospital	Medicine
Naughton, James L.	University of California Hospitals	Medicine
Nortman, Donald F.	University of California Los Angeles Hospitals	Medicine
ole Moiyoi, Onesmo K.	Peter Bent Brigham Hospital	Medicine
Orellana, Tessa D.	Children's Hospital Medical Center	Pediatrics
Orkin, Stuart H.	Children's Hospital Medical Center	Pediatrics
Pagon, Roberta A.	Children's Orthopedic Hospital, Seattle	Pediatrics
Paneth, Nigel S.	Bronx Municipal Hospital Center	Pediatrics
Pavan, Mary A. H.	University Hospitals of Cleveland	Pediatrics
Pavan, P. Reed	University Hospitals of Cleveland	Medicine
Pellegrini, John L.	Peter Bent Brigham Hospital	Surgery
Perencevich, Nick P.	Peter Bent Brigham Hospital	Surgery
Pierce, Letitia P.	Strong Memorial Hospital	Pediatrics
Popper, Charles W.	Massachusetts General Hospital	*Psychiatry
Powell, Robert O.	Massachusetts General Hospital	Surgery
Renna, Theodore	Mary Hitchcock Memorial Hospital	Medicine
Rettig, Philip J.	Yale-New Haven Medical Center	Pediatrics
Riggs, Suzanne G.	Massachusetts General Hospital	Pediatrics

Romero, Jorge A.	University of Chicago Hospitals and Clinics	Medicine
Rosenberg, Mark L.	Massachusetts General Hospital	Medicine
Rosenthal, Sara G.	Presbyterian Hospital, New York	Medicine
Roser, Stephen M.	Massachusetts General Hospital	Surgery
Sagar, Stephen M.	Peter Bent Brigham Hospital	Medicine
Saxon, Andrew	Los Angeles County Harbor General Hospital	Medicine
Schemmer, John A.	Boston City Hospital (Harvard Service)	Medicine
Schlessinger, Leslie	Boston City Hospital (Harvard Service)	Medicine
Schoonover, Stephen	Beth Israel Hospital	*Psychiatry
Schulman, Alan N.	Beth Israel Hospital	Medicine
Scott, James P.	Highland Hospital of Rochester	Family Practice
Shimshak, Robert R.	Jewish Hospital, St. Louis	Medicine
Sigelman, David R.	Massachusetts General Hospital	Pediatrics
Smith, Daniel H.	Massachusetts General Hospital	Surgery
Smith, Frank L.	Peter Bent Brigham Hospital	Surgery
Smith, Henry F.	Massachusetts Mental Health Center	*Psychiatry
Soverow, Gary J.	District of Columbia General Hospital (Georgetown Service)	Medicine
Sparks, John W.	University of Colorado Affiliated Hospitals	Pediatrics
Steiner, Robert W.	The Cambridge Hospital	Rotating
Steinglass, Kenneth	Presbyterian Hospital	Surgery
Sviokla, Sylvester C.	University Hospital of San Diego County	Surgery
Swedlow, David B.	Johns Hopkins Hospital	Pediatrics
Toth, Eileen R.	Harlem Hospital, New York	Medicine
Tria, Alfred J.	Roosevelt Hospital, New York	Surgery
Trowbridge, Cathryn R.	University of California at Los Angeles Affiliated Hospitals	Pediatrics
Trowbridge, John F.	University of California at Los Angeles Affiliated Hospitals	Medicine
Vinson, Robert K.	University of Michigan Affiliated Hospitals	*Urology
Waitzkin, Howard B.	Stanford University Affiliated Hospitals	Medicine
Waksmonski, Carol A.	Peter Bent Brigham Hospital	Medicine
Walsh, B. Timothy	Mary Hitchcock Memorial Hospital	Medicine
Weller, Peter F.	Peter Bent Brigham Hospital	Medicine
Whyman, John S.	Montefiore Hospital	Medicine
Wynia, Virgil H.	North Carolina Memorial Hospital, Chapel Hill	Medicine

* Residency

The Persistence of Medical Quackery in America

Some reflections on the complex and subtle interrelationship among three parties: the citizen as patient; the orthodox practitioner; the quack himself.

by James H. Young, Ph.D.

DUTCH painters of the 17th century excelled at showing the realities of the common life, and this included quackery. Last summer I saw two portraits of charlatans beguiling their victims; one at the Frans Hals-museum in Haarlem, painted by Adriaen van Ostade, the other at the Rijksmuseum in Amsterdam, painted by Jan Steen. Ostade's quack boldly displays a bottled nostrum whose reputed wondrous powers we can now only surmise, while Steen's quack, with triumphant flourish, produces the stone he has just ostensibly removed from the brain of a poor halfwit who cowers beside him.[1]

Quackery, of course, long antedates these revealing paintings, stretching back to the day, so Voltaire said, when the first knave met the first fool. The great antiquity of quackery does not surprise us; what seems harder to comprehend is quackery's persistence. Boerhaave was born while Ostade and Steen still lived, but quackery outlasted Boerhaave as it has outlasted Jenner, Bernard, Pasteur, Koch, Ehrlich, Osler, and any more recent giants in medical science we may wish to add.

To be sure, quackery's demise has often been predicted. This has certainly been so in America. A line of thought based on the Enlightenment concepts of the Revolutionary generation held that we were a reasonable people, and if error persisted here and there it would soon vanish because of our corporate good sense. Problems were for solving, swiftly and totally, each success lofting us a level higher in our inevitable progressive ascent. All of this meant, as we have recently come to realize, that for a long time we tended to brush some of our gravest problems under the rug. The problems existed, indeed were much discussed, but were not seen for what they really were. They seemed like aberrations rather than integral features of our national life. They were blocked out, minimized, or viewed in a distorted way, because they did not square with the overall vision, the consensus patterns, with which many Americans had come to regard the national dream and dynamism. Among these problems are poverty, bigotry, and violence. Among them too is quackery.[2]

Quackery, in terms of this argument, was acknowledged to be an evil but was considered transitory. When the populace had received a little more public schooling, when science had expanded its horizons a little further, or when Congress had enacted such-and-such a protective law, then would quackery vanish, consigned to the museum of outmoded delusions. Quackery was not a constant of American experience, but a temporary deviant whose vanquishment lay just around the corner.

"Quackery . . . is the legitimate offspring of ignorance," asserted an orator at the opening of a new medical school in Nashville in the middle of the 19th century, "and can only be abridged by elevating the standards of medicine, and disseminating a correct public sentiment."[3] The new medical school brought closer that enlightened day. The same physician upon another occasion insisted with equal optimism: "Let but the composition of secret remedies be once known in the community, and the death knell to empiricism will have sounded."[4]

In 1906 when the Congress did get around to passing a law that required a modicum of accurate data on patent medicine labels, the American press updated the cheerful view of half a century before. As a result of the new act, the *New York Times* editorialized, "the purity and honesty of the . . . medicines of the people are guaranteed." The new law, exulted the *Nation,* would deal harmful nostrums a "death-blow."[5]

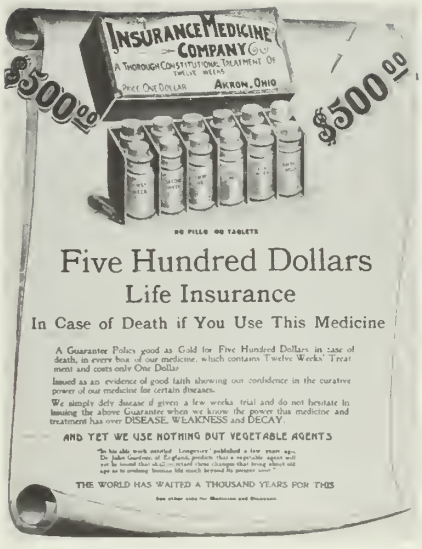
And so it has continued into more recent times. When the 1906 law was strengthened in 1938 during the New Deal, predictions of the disappearance of quackery may not have been quite so categorical, but prospects seemed rosy enough. At last

Dr. Young is a professor in the department of history at Emory University. This article, based on a lecture Dr. Young presented last fall as part of the Harvard Medical School's Program in Medical History, appears in the May-June issue of *American Scientist,* in a slightly longer version.

the Food and Drug Administration (FDA) possessed a law with something like adequate teeth. And they set to work to bite down hard on the most flagrant forms of quackery. Simultaneously, both physician and layman became engrossed with the miracle of chemotherapy. Was it not a fair assumption that, as the sulfas, penicillin, and other new prescription drugs expanded their zone of lifesaving potency, the territory should shrink in which quacks could profitably operate? Coupling this with earnest enforcement of the 1938 law, was it too much to hope that quackery might vanish completely?[6] Thus, at various stages and in slightly altered forms, optimism has persisted that something as alien as quackery to the central American myth of goodness, rationality, and progress must be about ready to disappear.

Every so often an observer has sought to dispel such optimism. Moved perhaps by a gloomy view of human nature based on theological rather than Enlightenment grounds, or simply primed by a pragmatic observation of the facts, some commentators have expressed doubt about quackery's moribund state. A decade and a half ago this happened again. Just as a few years later an affluent America was to rediscover poverty, so in the mid-1950's a scientific America rediscovered quackery. Dedicated enforcement of the 1938 law, it seemed, had not been enough to squelch quackery, nor had expanded education, nor had penicillin.[7] Indeed, the experts began to assert, with considerable surprise, that the annual cost to the nation of quackery's deceptions amounted to a billion dollars.[8] By the mid-1960's estimates had escalated to two billion dollars.[9] Nor was the United States unique, although special circumstances might make for a somewhat different pattern here. The World Medical Association published an issue of its official journal devoted to health quackery around the globe.[10]

Why is this situation so? How to explain quackery's persistence? I



suspect this is an Archimedes-lever question. Had one the full answer, one would be standing so as to move the world toward omniscience. My expectations must be much more modest. Health quackery obviously involves a complex and subtle interrelationship among three parties: the citizen as patient; the orthodox practitioner; the quack. Let us examine some of the characteristics of each of these parties that, in their interaction, help explain quackery and its stubborn persistence.

The Citizen as Patient

First of all, John Doe, citizen and sometime patient. It was Oliver Wendell Holmes who observed: "Somebody buys all the quack medicines that build palaces for the mushroom, say rather, the toadstool millionaires."[11] Indeed, no one has discussed the dynamism of quackery with keener insight and sharper wit than has Holmes in his *Medical Essays*. In Holmes' day and in our own, John Doe confronts the extremely complex field of disease and possible therapy with some sound information and some misinformation. What he knows usually turns out to be a jumble of uncoordinated impressions and attitudes learned by word of mouth from grandparents, parents, and maiden aunts, from teachers and coworkers, doctors and nurses, and from reading schoolbooks, magazines, and newspapers, including the advertisements. Statistically, perhaps, most people may be nearer right than wrong, but few escape blindspots and areas of error that make them vulnerable to quackery under suitable circumstances. This goes for some John Does of mighty intellect with various degrees after their names.

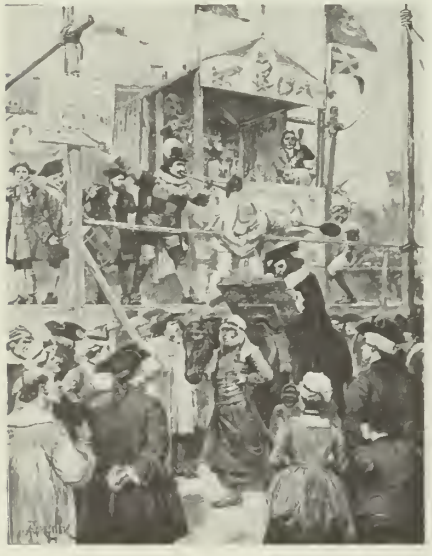
When an episode of ill health looms, John Doe faces it either by self-reliance or by seeking help from a health authority. If he chooses self-treatment, he tries some remedy from the folk tradition or from his recent reading or television viewing, perhaps garlic from the garden, a huge dose of Vitamin C, or a trade-named tonic. He tends to judge results by the same rule of thumb common sense by which he evaluates routine cause-and-effect sequences: did the axe cut? did the suit fit? did the motor run? He asks: Did my symptoms disappear? Did my digestion settle down? Did my nerves calm? Did my sniffles abate?

Matters he does not understand tend to invalidate such simple analysis. John Doe seems largely unaware that many ailments are self-limiting. Thus he continuously falls prey to the post hoc, ergo propter hoc fallacy. He experiences a symptom; he doses himself with a remedy; the symptom vanishes; the remedy gets the credit for the cure. Thousands of John and Jane Does have boosted the fame of folk remedies and have signed sincere testimonials for patent medicines under the influence of this fallacy.

Nor does John Doe take into account the placebo effect. Henry K. Beecher '32, Henry Isaiah Dorr Professor of Research in Anaesthesia, Emeritus, at Harvard has demonstrated what a powerful force toward symptomatic improvement resides in this response to the act of being treated, whether the affliction be minor or grave.[12] The placebo effect in self-medication is currently a subject of burgeoning discussion. The Food and Drug Administration confronts the problem of how to handle over-the-counter medication

under the Kefauver-Harris Act of 1962, which requires that all medications be demonstrated effective as well as safe prior to marketing. Most attention to date has been focused on prescription medication. The law aimed retroactively at requiring proof of effectiveness for drugs that had reached the market under the new drug provisions of the 1938 law, and comparatively few self-treatment medicines fell into this category. Where such over-the-counter medicines came before the National Academy of Sciences/National Research Council (NAS/NRC) review panels, I think it fair to say, grades for effectiveness given by panel members have been generally low. Summing up, Dr. Charles C. Edwards, Commissioner of the FDA, told a Senate committee hearing: "The NAS/NRC panels concluded that approximately 15 percent of the drugs were effective, 27 percent probably effective, 47 percent possibly effective, and 11 percent were ineffective for the claimed indications."[13] As a result, will the FDA sharply curtail claims permitted to be made in the labeling of such medicines? The agency is just mounting the machinery to make this effort. Will the FDA be able to expand its effectiveness controls to older self-medication drugs not specifically included under the 1962 law? The agency has avowed it will try, and to some degree industry may be expected to resist. If industry is forced to yield, it will seek a compromise, I suspect, by which the definition of effectiveness would cover not only biomedical but also psychological factors, to wit, the placebo effect. For industry certainly knows about the placebo effect, even if its best customers do not. Proprietary promoters, by the nature of their advertising, reveal that they concur in what Commissioner Edwards told a Senate committee. "The sedative market," Edwards said, "is easily open to exploitation since 30% to 70% of any group of persons tested will experience relief of anxiety when given a placebo or inert substance and told that it will be effective."[14]

Quack offering cures in show staged in public market. Engraving, 1886.



A Washington attorney, speaking recently about the older proprietary medicines, explicitly used the word "effective" to cover the customer's emotional response.[15] "Very often," he said, these pre-1938 proprietaries "treat only subjective complaints." But that should be adequate, he thought. Congress should not change the law, and presumably the FDA should not change the regulations, to bring more demanding standards of effectiveness. The placebo effect alone should be warrant for marketing. "An absolute obeisance to science," the lawyer said, "may not be what the public requires — something more rough-and-ready may answer as well."

Complicating this looming policy decision as to whether or not so free a use of the placebo effect as a promotional method will be permitted proprietary manufacturers is the recent concern about the role of advertising in making drugs seem like a solution to any problem. Some commentators, Congressional and otherwise, have posited that youth's readiness to experiment with dangerous drugs owes something to the vibrations emanating from television drug commercials. Gerald Thain of the Federal Trade Commission points out that many ads depict "common behavior" like "snapping at your wife" "as a disease," which over-the-counter medicines can cure.[16] "It would seem," Thain adds, "that if human problems are continually described in terms of disease and if the advertisers never disclose that a problem can be solved without drugs, the public will come to believe in the efficacy of drugs" to solve such problems.

With the placebo effect so central to the success of the most reputable of self-dosage medicines, it obviously has had a primary role in the maintenance of quackery.

The John Doe I have been talking about turns to self-treatment occasionally when meeting a disruption in his normally healthy life. For some of his unhappy cousins, a constant fear of imminent health disaster, an all-consuming anxiety about the overwhelming hazards of existence, leads to continuous self-treatment, with an often bizarre regimen of self-administered preventive medicine. People of this sort may use all-inclusive systems, or try one for a while and then move on to another, systems mixing diet practices, exercises, gadgetry, and mystical philosophies or alleged religions. The genuinely distraught, although a minority of the population, provide an important reservoir for quack exploitation.[17]

Often, of course, such misfits abandon self-treatment and join a guru-led group, just as less extreme John and Jane Does may eschew self-reliance, or, finding it unavailing, seek help from some authority. A great lack of sophistication has always existed, and still exists, about who is a competent authority in the health field. Many people who intend to consult the most respectable authority have gone astray. If a neck or back injury is involved, the chiropractor may seem the obvious choice in the long list of polysyllabic specialists.

Other patients turn to less-than-scientific practitioners under the miss-no-bets philosophy. They believe in their family doctors as treaters of organic ailments and prescribers of drugs. They also believe in

chiropractors as manipulators of bones and perhaps as operators of "healing" machines. They likewise give credence to the nutritional counsel of food faddists and distort their diets. And they sense nothing wrong in all this therapeutic simultaneity: the good and the bad, in their minds, have equal relevance and value. No physician should be surprised, Sir William Osler once said, if he should "discover accidentally a case of Warner's Safe Cure in the bedroom of . . . [his] best patient."[18]

Still other patients have an authority problem and tend to reject the orthodox because it is the orthodox. These people may be so insecure that they are overawed by the confident and mighty, or they may be angry rebels against those in places of power. At certain points in history, for reasons far beyond the circumstances of the medical profession, such antiestablishmentarianism has gone to great popular lengths. One facet of Jacksonian democracy was a suspicion of too much book learning.[19] "The priest, the doctor, and the lawyer," wrote a medical irregular, were all guilty of "deceiving the people."[20] And the people responded to this alleged maltreatment by turning elsewhere. A committee of the New Hampshire Medical Society reported "so strong an antagonistic feeling" between physicians and the public that the people considered "their reliance upon nostrums and quack administrations of medicine more valuable than any dependence upon a learned profession. The profession to them is 'pearls before swine.' "[21]

Something of this sort, although not so widespread, developed in the 1950's, with a highly vocal picketing and letter-writing minority supporting irregular medicine against an alleged conspiracy that allied regular physicians, pharmaceutical manufacturers, medical research foundations, and governmental regulators against the people's interest.[22] And in our own day, the wave of hostility towards the establishment and the crusade for a counter-culture, among their vast ramifications, do open doors for quacks.

One other point about the patient: when his health is seriously threatened he obviously hopes something may be done to keep him alive, to cure him. His desires may outrun what responsible orthodoxy can promise to accomplish. Confronted with this ultimate crisis, many citizens who never before strayed from orthodox treatment are now unable to accept orthodoxy's grim verdict and turn elsewhere. Such desperation has fattened cancer quackery.

The kind of patient I have been describing is not the John Doe taken for granted through the course of American history by those optimists who saw quackery as near to extinction. That patient was a man of prudence and good sense who, given a bit more education in matters medical, would eschew quackery altogether. Health and disease are terribly complex, and the power of unreason may often outweigh reason as a motivating force. Any major current view of man's basic nature, I believe, would have to envision quackery's continuance.

The Orthodox Practitioner

Having looked at some of the parameters of the citizen as patient, let me consider the orthodox physician's relationships to the patterns of quackery. Orthodoxy is not easy to define. Perhaps its two main features may be said to be knowledge and power. And let us grant that at times in history these might be read as false knowledge and undue power. One might argue that in earlier ages orthodoxy was characterized more by the sheer power of the medical establishment and less by the persuasiveness of its medical knowledge than in more recent times and that, as the state of medical science improved, the task of drawing the line between orthodoxy and quackery became easier. But orthodoxy has always believed its current knowledge valid and has exhibited a tendency toward smugness. It is easy in retrospect to recognize the error in the massive bleeding and purging of the so-called heroic age of American medicine, or in the huge doses of opium prescribed during the 19th century. Yet within our own century, physicians have prescribed large amounts of radioactive waters and surgeons have performed colectomies as cures for constipation. Although the line may be easier to draw than once it was, no current orthodoxy can be accorded the sanctity of ultimate gospel.

Nor can we ever assume that orthodoxy has meant unanimity. Eighteenth-century proponents of diverse monistic systems dwelt within the orthodox tent but jousted furiously. And today two sharply contesting groups, both orthodox, debate the proper role in medicine of several drugs deemed ineffective or only possibly effective by the NAS/NRC panels — on one side academic specialists who think controlled studies should define effectiveness, and on the other, general practitioners who rely on observations while using the drugs with their private patients.

Whatever the difficulties, orthodoxy has always sought to define itself, and hence to define unorthodoxy as well. The prevailing definition has occasionally been so rigid as to impede legitimate innovation. All latter-day quacks, especially when hard pressed, have trafficked upon this circumstance, calling them-

selves Galileos, Semmelweisses, and Listers, scientists ahead of their time suppressed by the greedy establishment. Or so the quacks' lawyers have termed them in court.

When orthodoxy's rigidity has been too extreme, it has led to countervailing pressures. The heroic bleeding and purging in the wake of Benjamin Rush's doctrines led eventually to a critique from within orthodoxy, by Oliver Wendell Holmes and others back from Paris. But this harsh therapy also led in part to the widespread retreat from orthodoxy on the part of common citizens somehow uneasy at losing teeth and even jawbones from too much mercury. In their retreat Americans welcomed various unorthodoxies. These included pleasantly flavored, allegedly nonmercurial patent medicines; the domestic cult of Thomsonianism; a revival of botanic medicine; and the imported cult of homeopathy with its infinitesimal dosages.[23] An extreme frontier version of homeopathy saw great value in a broth made from boiling water containing merely the shadows of dead pigeons hung in the kitchen window.[24]

Our more recent age of heroic medication may also have diverted some citizens toward unorthodoxy. The overuse of penicillin may have had the valuable unintended side-effect of curing many cases of venereal disease among people who never knew they had it. But, on the other side of the ledger, the overprescription of antibiotics, corticosteroids, tranquilizers, amphetamines, and other potent products of the chemotherapeutic revolution, among their dire consequences, enlarged the category of therapeutic misadventure, helped create a stereotype of our "drugged" nation, and gave drugless healers a promotional boon. I have had letters, at least one accompanied by color photographs, from people driven into angry unreason by the catastrophic consequences of adverse drug reactions to members of their family. In the early 19th century, quacks termed the doctor a butcher; today quacks sometimes call the orthodox physician a poisoner. Thus the uncertainties encountered at the cutting edge of medical development, including overenthusiastic exploitation of new discoveries, can redound to the benefit of the quack.

Orthodox physicians, moreover, have a problem because of their power and status. In the very nature of things, non-experts feel ill at ease in the presence of an expert. And often the circumstances in which the expert functions aggravate the tensions. The patient is upset because he is ill and worried. The physician is busy and under pressure so that intruding upon his time is an added cause for uneasiness for the patient.

The doctor is often brusque, does not take time to listen, neglects to explain. His prognosis may be discouraging, his therapy protracted and unpleasant. He charges a lot, earns more, lives better than the patient, perhaps a cause for latent irritation and envy. Some patients are just plain frightened away from reputable doctors whose rapport falls below that which quacks are able to muster.

Even patients who get along well with their own physicians may think ill of doctors as a whole. The power side of establishment medicine has alienated many people. Organized medicine, they have felt, works for its own economic and political self-interest more than for the healthy common good. Pronouncements sound pontifical. Such an image helps quackery. For, through history, any criticism of the power, as well as of the science, of orthodox medicine has been pounced on by the quack, magnified, and trumpeted abroad.

The Quack

Some points I have been making suggest that doctors might improve their human relationships. Other points may be so inherent in the existential situation as not to admit of much modification. Certainly the integrity of a doctor's diagnosis and therapy, whatever its wisdom, distinguishes orthodoxy from quackery. The physician seeks to help his patient if he can, but must sometimes confess that he cannot. The quack need make no such confession, because for him integrity is not, as for the good physician, a sine qua non. This permits the charlatan countless advantages in competing with the physician for the kind of patient I have described. For the quack can tailor his appeals to all the susceptibilities, vulnerabilities, and curiosities which human nature reveals.

If true medical science is complex, the quack can oversimplify. All diseases are catarrh, and Peruna cures catarrh. If some ailments are self-limiting, the quack makes nature his secret ally, crediting his tonic for curing consumption when in fact nature has alleviated postnasal drip.

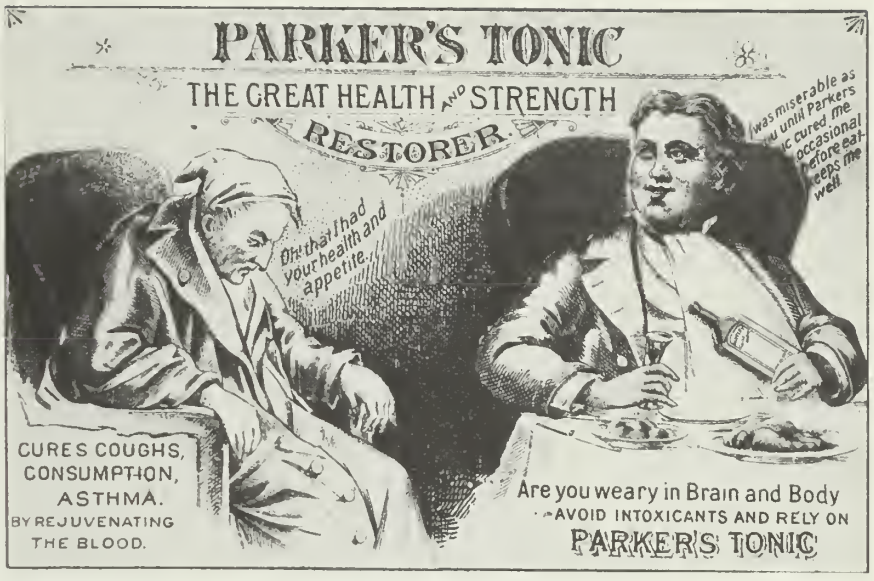
If the placebo effect is powerful medicine, the quack prescribes it adeptly. It may be something for arthritis as ancient as a copper bracelet or as modern as the purported moon dust which turned up not long ago in Memphis.[25] Or it may be an unforgettably heroic treatment for an ailment that did not exist even in the patient's own mind until 15 minutes before.

Imagine this 19th century scene: a sidewalk anatomical museum displaying wax models purporting to show the ravages of syphilis and the dire consequences of self-abuse. At-

tendants hover around watching young men who chance to look in at the exhibits turn pale. Immediately an attendant buttonholes each sobered youth, elicits answers with skillful questioning, and ostentatiously performs a urinalysis. If a diagnosis of syphilis seems called for, he adds an iron compound to get a red precipitate. If onanism appears more in accord with the case history, he adds silver nitrate. Both tests seem equally impressive, indeed, staggering. In either case, the treatment is the same, and it is staggering too, a curative punishment to fit the crime. The frightened youth sits on a sort of toilet seat, his bare back against a metal plate, his scrotum suspended in a swirling pool linked by wire to the plate and to a battery. The attendant impresses upon the patient the message that the efficacy of the treatment equals its rigor. Note that those who avail themselves of such a "clinic" may have been suffering from nothing more grievous than a guilty conscience. Had they happened to walk along a different street, even that problem might not have crossed their minds. And yet, as they stagger away from the encounter, they believe fervently that they have been desperately ill and now are well again.[26]

The quack pays more attention to the person than to the ailment, seeking to enlist the patient's sense of conviction that treatment is necessary. Fright may be used, as in the instance just cited. Ralph Lee Smith, in his book *At Your Own Risk,* tells of infiltrating a school run by a Texas chiropractor aimed at teaching other chiropractors how to increase their income.[27] "If the [would-be] patient has a pain in his left shoulder," the professor said his pupils should inquire, "Has the pain started in your right shoulder yet?"

Along with fright goes tenderness. The quack manages a superb bedside manner. Since he cannot really provide a cure if major disease is present, he vends promises, sympathy, consideration, compassion. The patient responds to this attention. This helps explain one of the



odd paradoxes relating to quackery, that failure seldom diminishes patient loyalty. When regulatory agencies seek to prosecute quacks, the agencies have a difficult task getting hapless users to testify in court. Part of this results from the desire to avoid public exposure as a dupe. But more of it rests on an inability to realize that deception has taken place. The quack has done such a good job of exuding sincerity and concern that the victim believes his false explanation that the specious remedy would have worked had only treatment begun a little sooner.

"They were all so courteous to me," one woman said of the quack doctors at a cancer "clinic" where she had been treated.[28] "I am going to stay with them no matter what else I do. The last doctor I went to was so abrupt to me. He said I was in some stage of cancer and the way he said it scared me to death. Now these people said, 'Look on the bright side and enjoy life all you can.' The doctor took all the joy out of living because he scared me to death. Now with these people, I feel safe and happy."

Thus the quack treats people kindly and promises them anything, a regimen that has long lured victims from among the uninformed, lonely, disturbed, and desperate. Efforts to educate against the dangers of quackery have met with only modest success. Efforts to control quackery by law have done slightly better. It seems unlikely for instance, because of the requirement of the Kefauver law that efficacy be shown before a new drug is marketed, that any new specious cancer treatment will reach the national peak which, in their hey-day, Harry Hoxsey's concoction and Krebiozen achieved. Still, regulators keep busy with other important tasks, their appropriations are woefully inadequate, legal procedures take years to reach fruition, penalties are seldom heavy, state laws are generally weak, and some nearby foreign lands permit quack promotions outlawed in our nation.[29] In view of this, as well as the quack's agility and the customer's eagerness, legal controls hardly seem likely to eradicate charlatanism.

The Future

Lately, indeed, I have begun to wonder if quackery's future has not brightened, because so many young people are assuming a posture that makes them highly vulnerable. Disillusioned because the promise of American society seems so blighted, these young people have rejected as untrue the traditional myth of what the nation stood for. Since reason lay at the center of the myth, countless young people, frankly rejecting reason, have turned against the myth and against science, regarded as rea-

son's way of seeking truth. Whatever merit may lie in suspecting reason's inadequacies, the reaction has gone to the extreme of deliberate flirtation, if not liaison, with wild varieties of unreason. Astrology soars, not as a pastime but for real. Publishing houses mint millions from it, while almost every campus has a peripheral course in reading the stars. Spiritualism is making a strong comeback, with "spiritual churches" blossoming in almost every city. Tarot cards, numerology, palmistry flourish. Paperbacks on these themes are among the hottest items in university bookstores from Cambridge to Berkeley.[30] And a recent article states: "Witches are surfacing everywhere."[31]

One may strongly sympathize, I hope, with much of the critique that the sensitive young make of our disordered world without following them in their headlong pursuit of unreason. In any case, the moods and feelings and stimulants to action in such a stance strike me as similar to the irrational conglomerate that quacks have used for centuries in promoting their wares. Hence, I conclude that those who embrace irrationality so fervently may furnish a fertile recruiting ground for unscientific health wares.

Thus, for many timeless reasons and for new reasons too, health quackery may be expected to continue. Despite the gloomy prospects, both education and regulation must be employed vigorously to restrain as much as possible quackery's toll in wasted resources and in human suffering.

FOOTNOTES

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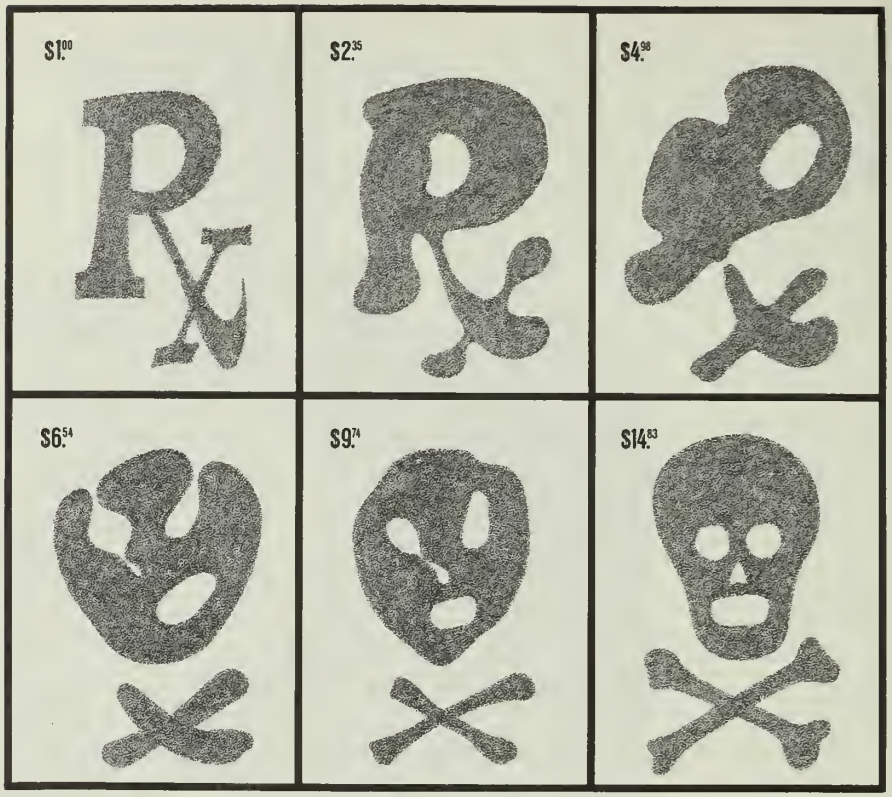
THE Nation is gripped by an epidemic of irrational prescribing practices on the part of doctors. The effects have been, and will be, more destructive than most members of the profession realize unless something is done.

Doctors are prescribing too many drugs. Nearly everybody knows it, but nothing is done about it. A distinguished clinical professor of medicine at Columbia recently testified before the United States Senate that, in his opinion, about 60 percent of prescriptions are unnecessary. From my own busy, private practice of internal medicine, I know that 98 percent of all patients can be adequately treated with 25 or fewer drugs and some of these need be used only rarely.

Overprescribing is the most serious form of irrational use of drugs by doctors. While one can quibble with figures, every doctor and medical student ought to know that the United States Food and Drug Administration is on record within the past year: approximately 1.5 million persons are admitted to hospitals annually because of adverse reactions to drugs and another 2.5 million have their hospital stays prolonged because of adverse reactions to drugs administered in hospitals. The FDA is not given to overstatement. Obviously, human and material costs of misadventures with doctor-prescribed drugs are incalculable. Most illnesses and symptoms are self-limiting, require no prescription, and doctors ought to tell this to patients.

The prescribing of toxic drugs when less toxic ones would suffice is another form of irrational prescribing. Knowledge that chloramphenical (one brand name, Chloromycetin®) can cause fatal aplastic anemia has been known to the profession since 1951. The drug is useful in typhoid fever. Yet, four million Americans received a course of Chloromycetin® for varied reasons including common urinary infections, common colds, even for infection associated with ingrown toenails as recently as 1967. There is no excuse for this irrationality. And



by Richard Burack, M.D.

it does not enhance the image of the profession to know that a Congressional Committee had to expose this scandal; the profession had taken no effective measures on its own to educate its members. Medical journals, including the superficial, parasitic "giveaway" sheets, had been advertising the drug heavily, and according to a distinguished business journal *(Forbes Magazine)*, Parke-Davis, Inc. had been receiving one-third of its income from the sale of Chloromycetin® in 1966.

There are many other examples: Tedral® for asthma instead of plain ephedrine sulfate. Tedral® is a fixed dose combination of theophylline (in a very small dose which is probably ineffective), eight milligrams of phenobarbital and 25 milligrams of ephedrine sulfate. Doubtless it is the latter which confers effectiveness on Tedral® and it is hard to understand why doctors expose their patients to possible toxic effects of theophylline and phenobarbital unnecessarily. Thousands of doctors routinely prescribe ampicillin for adults where less toxic tetracycline would almost always serve as well. They also prescribe concoctions containing systemic vasoconstrictors like pseudoephedrine and phenylethanolamine for people with stuffy noses. Constricting all the blood vessels in the body in order to constrict the blood vessels in the nose seems the height of folly. Most patients who are given such drugs would do as well with salt-water nose drops or drops with a local vasoconstrictor such as phenylephrine. Another example in this category is the habit of prescribing Indocin® routinely instead of aspirin for patients with arthritis.

Doctors are prescribing expensive drugs where less expensive one would suffice: V-Cillin-K® instead of penicillin G, ampicillin instead of tetracycline, Gantrisin® instead of triple-sulfa tablets, various sedatives ranging from Serax® to Serentil® to Sinequan®, instead of chloral hydrate or phenobarbital. Few doctors know and too few students have been taught that the wholesale cost of two of the most popularly prescribed

tranquilizers equal 25 times the official cost of gold for one, and ten times the cost of gold for the other.

Doctors have been prescribing therapeutically unnecessary and unnecessarily expensive combinations of drugs, some of which are, or may be, ineffective: Azogantrisin® instead of triple-sulfa tablets; Achrostatin® instead of tetracycline with the advice to take a couple of aspirin tablets, too; Panalba® instead of tetracycline; Colbenamid® instead of probenecid (now available inexpensively) plus a little colchicine as needed; Darvon Compound-65® instead of codeine sulfate plus the advice to take two or three aspirin tablets, too; Novahistine® instead of either an inexpensive antihistamine or low cost over-the-counter nose drops containing phenylephrine (the best known brand is Neosynephrine®). The list is very long because approximately 40 percent of the medicines prescribed by doctors are so-called fixed dose combination items, nearly every one of which is unacceptable to the Council on Drugs of the American Medical Association, The United States Pharmacopeia, and the National Formulary. The standard argument given by colleagues who prescribe such things is that it's so much more convenient for a patient to swallow one pill instead of two or three. The counter-argument is that most doctors are relatively affluent with respect to most patients who might well prefer a minor inconvenience in order to save some money. Ten percent of the population purchase 25 percent of the drugs. Within this ten percent are the elderly and most of those live on small pensions or social security.

Doctors prescribe expensive "new" drugs instead of less costly older (and, therefore, probably safer) ones. Lomotil® is all too often given routinely instead of paregoric for diarrhea. Banthine® and Probanthine® are nearly always prescribed instead of atropine sulfate or tincture of belladonna even though there is no convincing evidence that they are therapeutically superior. Atarax®, Vistaril® (they are chemically the same), Serentil® and Suavatil® are prescribed by many doctors instead of phenobarbital or chloral hydrate. Recently, I have noted the easy adoption by many physicians of something called Dalmane®, a sleeping medication. What is wrong with inexpensive barbital, secobarbital, and pentobarbital?

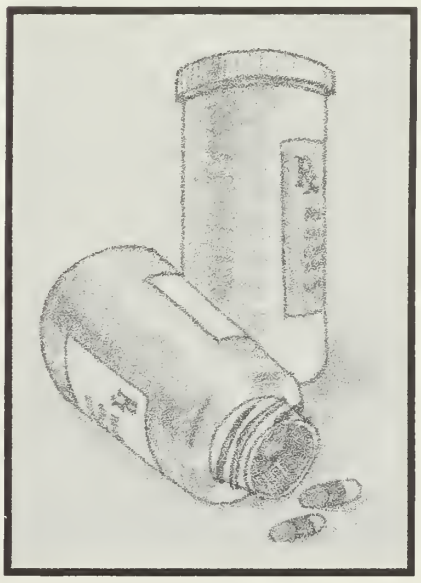
Many readers will be able to add to the list of irrational ways that so many members of our profession prescribe medicines.

The reasons for irrational prescribing are multiple, but they boil down to economics and mass promotion. A highly monopolistic drug industry has taken away doctors' individualism and has managed to tell them how to prescribe. About five thousand dollars per doctor per year is spent to this end; that is about one billion dollars — more than it costs annually to administer all of the medical schools in the United States. The slick (and too often noncompostable) parasite press drums propaganda in the doctors' ears and itinerant salesmen who are euphemistically called "detail men" flatter doctors, give them little gifts, ply them with "samples" of new drugs and persuade them with carefully rehearsed "spiels" to "try it, Doctor, and you'll see." Professional people have no business receiving their "education" from advertisements and salesmen. No thoughtful doctor would use a lawyer whose decisions might be influenced by advertising and promotion.

Our very authoritarian profession has been a perfect set-up for insidious infiltration by the drug industry. A few big professors have been flattered and/or given subsidies of one kind or another and this is all it takes to mute their voices. They know that the goal of the industry, as an industry, is to maximize profits. They know that this is done by inducing busy doctors-in-the-trenches to prescribe more drugs than needed and make as much profit on the sale of any individual drug as possible. These are not the goals of good doctors. It is strange indeed that the influential members of our profession have not made it crystal clear to medical students that the aims of doctors and the aims of drug manufacturers are antithetic and irreconcilable. The influential ones have utterly failed to tell medical students and young doctors-in-training that when a doctor writes a prescription for a patient, he is functioning as a purchasing agent. Purchasing agents are expected to know the costs and comparative costs of things they order and something about the comparative efficacy. Purchasing agents in good stores are not allowed to accept gifts from vendors, either. If they do, they are fired. And men in political life, who conduct themselves similarly, are immediately labeled "corrupt."

There is no blinking at the facts and there obviously is every reason for the medical leadership to take strong steps to clean house. What is best for patients is in the long term best for doctors. But while I cling to hope, I am not optimistic that the medical profession will act by itself. Money, power, privilege, and vested interest are no less powerful hormones today than they have ever been.

Mark this, though, and mark it well: the political leadership and increasing millions of citizens recoil at the thought that artifically-induced markets and overly-inflated industries are tolerated within the field of health care.



A Psychiatric Glance at Malaysia

by Ernest Kahn '44

To REACH Malaysia you fly to the equator and then half way around the earth. The Malay Peninsula is at the south-eastern corner of the Asian mainland. It is attached at its base to Thailand and washed on one side by the Indian Ocean and on the other by the South China Sea. At the end of this peninsula lies Singapore. Just north of the equator is the capital of Malaysia, Kuala Lumpur.

When you are in Kuala Lumpur, you are about as far away from the Harvard Medical School geographically as you can get. But in some ways you are closer than you think. The dean of the new University of Malaya Medical School spent more than a year at Harvard, as did the professor of psychiatry; and their library is modelled on the Countway.

Eng-Seong Tan, professor of psychiatry, studied at Massachusetts Mental Health Center, where I supervised his work in psychotherapy. When he invited me to spend the summer in his department in Kuala Lumpur, I jumped at the chance.

Malaysia is a fascinating place to teach psychiatry because in that strange, complicated culture, all the medical students speak English and many of the patients as well. All Medical School classes are conducted in English. That is because the Malay Peninsula came under British rule in the 19th century and remained a British colony for about 100 years.

The University of Malaya, which is on the outskirts of Kuala Lumpur, opened in 1959, and five years later, the first class entered the Medical School. Today, the Medical School is about the same size as Harvard. At the center of things is the University Hospital, an immaculate, 14-story building with 750 beds. One floor is devoted to psychiatry and is staffed by approximately five psychiatrists and a small group of residents. These psychiatrists represent half of the total in Malaysia, where the ratio to the general population is about one psychiatrist per million people. This is not surprising in a country where malaria and malnutrition are still major problems. On the other hand, the mere presence of the department of psychiatry is progressive when compared to nearby Singapore Medical School which has no department at all. For the time being, the main effort of the teaching psychiatrists in Kuala Lumpur is to graduate better general practitioners rather than to train more psychiatrists, because there is also a physician shortage in Malaysia.

Indigenous Psychiatry

A recent survey of first-year Malaysian medical students indicated that about 25 percent of them believed that some mental disorders were due to spirits and demons. This reflects the firmness with which this ancient concept is still held. Although their cultural patterns are widely divergent, all the principal ethnic groups — Malays, Chinese, and Indians — share the belief that possession by some supernatural force causes mental disorder.

The Malays, whose original customs and beliefs were animistic, have been influenced by Hinduism (since the 3rd century), Islam (since the 15th century), and the West (since the 16th century). The traditional medical system remains animistic. Their ceremonies are partly Hindu, the religion Islamic, and there is a thin Western veneer.

The belief in spirits still permeates Malay life. From birth until death, a Malay man is involved in rituals pertaining to spirits. Even before he is born, his mother must carry a knife or iron to ward off spirits. In infancy, the baby is given various talismans against worms, fever, convulsions, and other illnesses. Psychotic behavior is often attributed to a "keramat," or spirit whom the patient has offended.

Among the Chinese, mental disorders are often seen as possession of the patient by the spirit of a dissatisfied ancestor. For the Indians, the possessing spirit is usually an offended Hindu deity. As a result of these beliefs, a patient with a mental disturbance or any form of illness is usually first taken to an indigenous healer. The Malay consults a "bomoh," or native healer, whether he has nightmares, pneumonia, or schizophrenia. The bomoh tries to effect the cure using various herbs, incantations, and charms to exorcise the demon or spirit. The Chinese seek the aid of a spiritual medium in a Taoist temple if possession is suspected. If the disorder is attributed to an imbalance of the yin and yang principles, a "sinseh," or traditional Chinese physician, is approached. The sinseh uses herbs, acupuncture, or magic to restore the balance. Often a Chinese patient sees both a medium and a sinseh. The Indians would go to the shrine of their favorite Hindu deity for assistance.

It is only when these indigenous sources of help have failed that the patient is brought to a hospital to be seen by a "Western" doctor. Among the psychiatric patients in the University of Malaya Hospital, approximately 90 percent of all ethnic groups previously had consulted indigenous healers. Sometimes the bomoh and the hospital work hand-in-hand. One local bomoh frequently refers his intractable mental patients to the hospital; another is employed as a ward attendant. Patients who go home for the weekend often consult a bomoh before returning to

the ward on Sunday evening. Because there are only about ten psychiatrists in all of Malaysia, the bomohs treat most of the psychiatric disorders in the nation. Only a very few patients reach the hospital and those who do tend to have flagrant disorders.

The department of psychiatry at the University of Malaya is conducting a survey of Malay bomohs, Chinese doctors, spirit mediums, acupuncturists, and Indian priests. Although they have varying degrees of knowledge, most seem sincere and quite helpful in treating mental illness. Almost all of them wanted to be most closely associated with Western medicine and were eager to refer their severe mental cases to psychiatrists. They are not just charlatans.

An example of a bomoh's technique has been reported by Dr. Paul Chen, professor of sociology. The patient was a man in his forties. When his father died, he was expected to take over the father's job, but could not because he began to have attacks of giddiness, apprehension, cold sensations, and anxiety. He also had a dream in which his recently deceased father appeared before him and ordered him out of the house. A bomoh was called. This particular bomoh was a nervous man who practiced in a trance. He set about his task by fumigating himself with benzoin fumes and muttering mystical incantations with his eyes shut. After a few minutes he indicated, by a twitching of his body, that he had become possessed. Then he interviewed the patient and it became clear that the patient was possessed by the spirits kept by his late father. These spirits were angry because the patient had not taken over the father's job. When the bomoh obtained this information he returned to normal. In the second session, held one week later before a group of friends and relatives, the exorcism was performed. The bomoh again became possessed and beat the patient with palm fronds until the patient began to twitch and the spirits were removed. At the conclusion of the performance, the bomoh's body jerked again and the assembled group feasted. The patient made a full recovery and took his father's job. A contemporary psychiatrist might say that the bomoh had provided a cathartic interview, used suggestion, relieved the patient's guilt, and offered his own and the group's support.

An interesting study has recently been completed on local Chinese healers (shamans) in Taiwan. Several shamans were carefully studied by psychiatric interviewers, one of them during and after a psychotic episode. It was found that these shamans had a special capacity for falling into trance-like states at will. These trances were closely related to dissociated states and would probably be considered as ordinary hysterical dissociation by most psychiatrists. The subject of native healers is complicated and has a large literature, but it seems that if one is to become a native healer, a little hysteria is a big help.

Some Comparisons to the West

Of the psychiatric patients admitted to the University Hospital, schizophrenics predominate, most of whom are very disturbed. There are several other mental disorders that seem to be peculiarly Asian. The most famous of these is "running amok." Amok derives from a Malay word and has come into common use in English. Running amok is a state in which a person suddenly becomes a homicidal maniac, seizes a knife, and rages through a village killing people at random until he is killed.

Westerners have been fascinated by amok for many years, perhaps because there is a little of it in all of us. Interestingly enough, when Kraeplin toured the East in 1904, he classified amok as an "epileptic dream-like state," which he thought might be due to cerebral malaria. A British administrator described it as "frightfully common among Malays" in 1846, yet a psychiatrist may now practice all his life in Malaya and never see a case. This is partly because it was tacitly condoned as inexplicable and unavoidable in the 19th century until 1893, when the British declared it a criminal offense and insisted on court trials and punishment for anyone who ran amok. After that it became rare. One of the explanations of running amok is that it is a Moslem form of suicide. Since suicide is forbidden to Moslems and is rare among Malays, running amok is a way of ending things and taking a few friends and relatives with you. However, it also occurs occasionally among Chinese and Indians. Most of the individuals who have run amok and then survived to be studied have been diagnosed as schizophrenics.

Latah is a brief, frenzied state seen in Malay women. It is less well known than amok, perhaps because it is less dramatic. It occurs as paroxysms of loss of control when a woman is startled. She then involuntarily imitates others and often uses repetitious, obscene language. Sometimes it is described as an automatic verbal explosion. People are inclined to taunt such a woman by clapping their hands just to hear her swear. Like amok, latah has become very rare. Frequently such women are tolerated and go on living in their village. They rarely come to the hospital, but when seen by psychiatrists, are usually diagnosed as borderline hysterics or schizophrenics.

Still another culture bound anom-

aly is koro, which occurs in southern Chinese men living in Malaysia and in other Asian nations. In koro, it is believed that the male genitals will shrink and retract into the abdomen at which time the afflicted man dies. Occasionally men are admitted to the psychiatric ward clutching their penes in a state of panic. Often, they are accompanied by their wives and children who are equally terrified. Special weights are sometimes attached to the penis to prevent its disappearance into the abdomen. It is a peculiarly literal example of castration anxiety. There was an outbreak of hundreds of cases of koro among the Chinese in Singapore in 1967.

In the past few years, there have been frequent outbursts of epidemic hysteria in girls' schools, so many in fact, that the Minister of Education has expressed concern. These tend to occur in Islamic parochial schools where all the students are adolescent Malay girls. What usually happens is that one girl sees a ghost or a vision and faints, whereupon panic spreads throughout the school, sometimes affecting 40 or 50 girls. It often becomes so disruptive that the school must be closed for a week or two. The whole cycle of events then repeats itself in another school in some distant part of the country. Epidemic hysteria is not exclusively Malaysian, or even Asian. It is seen all around the world, but it constitutes a special problem in Malaysia today.

Certain conditions are conspicuous by their infrequency. Among these are alcoholism and homosexuality. Some alcoholism is seen in Indian men working in Malaysia to support their families in India, but among Malays and Chinese, it is virtually nonexistent. For Malays who are Moslems, alcohol is forbidden. The Chinese have no moral prohibition against drinking, but drinking is confined to men and done mostly at mealtime. Drinking alone and drunkenness are not condoned.

Homosexuality is an uncommon complaint in all three ethnic groups. This may be because the homosexual is accepted and not subjected to social pressures. Furthermore, the general demand for sexual performance among young Malays is less than in the West. This, combined with the generally suppressive attitude toward all sexual discussion and behavior, and widespread prostitution, may account for the lower incidence of homosexuality.

Cases of senile psychosis are rarely seen in the hospital. This is partly due to the shorter life span and to the strong sense of filial loyalty especially among the Chinese, who keep their elderly at home.

Marijuana, although illegal, is now widely used by young adults. It is easily obtainable because it grows wild in Malaysia and it is also used medicinally by bomohs for such conditions as asthma, impotence, and headache. Across the street from the University Hospital, there was a coffee stand where marijuana could be purchased. Despite the prevalence of marijuana, hard narcotics do not present a problem to youth. There is virtually no heroin addiction and the few opium addicts are usually older Chinese men who brought their habit with them from China.

Medical students participate in field study.

EVEN during a short visit of two months, one gets certain clinical impressions. It seemed to me that the most common psychosis was paranoid schizophrenia. Religious delusions and preoccupations were frequent, perhaps because religion plays an important part in everyone's life. Paranoid schizophrenics tend to end up in the hospital because they are often disruptive to their families and communities.

Depression was less common than it is in Boston, and when it did occur, the presenting complaint was usually somatic; headache, fatigue, anorexia. Few patients complained of depression as such. The reasons why there is less depression are complex and elusive, but a few suggestions may be made. Among the Chinese the relationship between mother and infant is close. Where mother goes, the infant goes, and when the infant must be left behind there is a close-knit extended family to take over. The family system provides abundant maternal substitutes. Divorce is uncommon and there are few broken homes. This contributes to a lower incidence of early loss.

It is interesting to note that the attitude toward death in all three Chinese religions (Confucianism, Buddhism, and Taoism) is different from the West's. To the Confucian, death is relatively unimportant as long as there are sons to perpetuate the family line and to pray for the departed. Buddhists and Taoists traditionally believe that death is merely a transitory stage. For many Chinese, death is just a phase after which the spirit passes to another state of existence. At the age of 60 the more conservative Chinese buys his coffin and se-

lects an attractive grave site. When death occurs, open mourning is encouraged. The bereaved is expected to display his grief; at large funerals, professional mourners are hired. In the months and years following the funeral, mourning rites are institutionalized by ceremonial visits to the grave and to the temple. One may see mourners at a Chinese temple burning incense and paper money any day of the week in Kuala Lumpur. In trying to explain the lower incidence of depression and pathological grief reactions, these factors stood out — less early loss, a greater acceptance of death, and institutionalized mourning rites.

University Hospital

Racial issues were often woven into the fabric of psychiatric problems. A 23-year-old Chinese girl was admitted in an agitated state with paranoid delusions. One of the central facts in her history was that she had been adopted in infancy by a childless Indian couple with black skin. Although it was obvious from her light skin and features that she was Chinese and the adoptive parents were Indian, they had insisted throughout her childhood and up to the time of her admission, that they were her natural parents. This was only one of the ways they denied certain facts, but it was a vitally important one. Another patient of mixed Chinese and European parents who was born near Kuala Lumpur believed himself to be an "outsider." This was his overriding concern. During childhood he felt unaccepted by both Chinese and European children. He came to America to study engineering but suffered bitterly when people thought he was an American Black and discriminated against him. When he returned to Malaysia with his engineering degree and took a responsible job, he still felt like an outsider, even though he was in his native land. He migrated to Australia to start afresh, but even that did not help. After a year in Australia, he returned to Malaysia, fell into a deep depression, and attempted suicide. A less pathological expression of this theme appeared in a professional man of Eurasian parentage who was preoccupied with breeding "pureblooded" pedigreed dogs. Still another example was an Indian woman of high caste, born and raised in Malaysia. Her schooling had been very proper and she had learned about such things as "the history of English coal mines, Wordsworth, and Dickens," but almost nothing about Malaysia. When her parents forbade her to marry a man from a lower Indian caste, she felt completely lost. She had nowhere to turn. She was a Malaysian citizen with a British education in an Indian family and did not feel at home anywhere.

In a more general way, the racial issue penetrates into virtually all aspects of Malaysian life. It is a constant subject of conversation and even when not discussing race, people worry about it. A number of young Malays at the University are as militant as some American minority groups and sizable numbers of Chinese intellectuals are considering leaving the country, or have already left. Parliament was disbanded after the 1969 riots and now that it is reconvened, "sensitive" issues cannot be discussed. Malaysia considers itself a democracy but a man may be imprisoned without a trial for two years for a political offense. Censorship is considered necessary and books are banned. Seen in this context, it is not surprising that racial and cultural issues should appear ubiquitously among psychiatric patients.

Every year the best students in the country apply for medical school. Those I taught were bright and able. But there was one conspicuous difference from Harvard Medical students: their relative passivity. Although they listened carefully to lectures and took good notes, they were reluctant to volunteer opinions or to ask questions during case conferences and seminars. Even when requested to express their doubts, they would not. This seemed to be related to what one might call the general avoidance of open aggression. Wherever one went, one observed an elaborate array of devices to cover hostility. If you challenged a taxi driver for overcharging you, he would giggle; if you criticized your cleaning woman, she might very well disappear and never come back even though she needed the job. Awkward situations that might make someone angry were handled by a go-between. The objective was to maintain an aura of surface pleasantness. It was better to avoid any relationship at all than to have one that was tainted with open antagonism. This applied to the poor Malay farmer as much as it did to the educated rich.

Why should people be so careful to control their aggression? This is a difficult question, and only one of the many left unanswered.

Author's Query

by Howard N. Simpson '35

SEVERAL months ago I inserted the following item in the *New York Times Book Review:*

Author's Query

For a prospective biography of Quentin Kraus Dalgleish III I would appreciate letters, photographs or other memorabilia.

J. Llewellyn Hafferstam, M.D.
613 Longwood Ave.
Boston, Mass.

In a way, this was a bit of a fishing expedition. The file on my friend Dalgleish was relatively complete, but I wanted to fill in a few obvious gaps. I realized I did not have enough material for a full-length biography, but believed that the man was a sufficiently significant literary figure to deserve at least a slim volume.

Quent Dalgleish and I had been roommates in Vanderbilt Hall back in the thirties. He had dropped out (to use a polite expression not then in common usage) from the Harvard Medical School and had made his mark in other fields. The man unquestionably had a spark (not exactly divine) of genius, but it never would have been put to work caring for the sick either in Boston or Brazil; nor would it have been profitably employed in research, developing the definitive therapy for Ainhum. I feel certain it was predestined fate whereby Quent partook of q.s. ethanol *prior* to the pathology exam rather than following it as was the current custom.

Frankly there were many times when I worried whether my recollections of Quent would actually make a complete story of the man's life. There were plenty of reminiscences. I remember the time when we had been thrown out of the Old Howard in Scollay Square because, due to some chemically released inhibitions, we decided we wanted to be part of the act. Then there was the event in South Boston when we broke up one of Jim Curley's political rallies with synthetic hydrogen sulfide. Also, there was the exploit Quent pulled off all by himself. A pompous pathologist at the Brigham was performing an autopsy in front of a distinguished gathering. The "subject" was a former, rather unpopular member of the faculty, who presumably had succumbed to an obscure and puzzling ailment. When

"part of the act at the Old Howard."

the chest was opened, the heart had been replaced by a stone. It was Quent's first, and only, posterior thoracotomy, but a highly successful one.

Quent had several skills, so when he departed the Medical School he had a variety of interests to occupy his attention. He composed light music and did it fairly well. He tried painting, but he was not an artist. Sometimes he turned to verse. During this period we were carrying on a fairly active correspondence. At one point, when I suspect he may have been drinking too much, he sent me a note saying he thought Mother Goose should be rewritten with a medical overlay. He offered this suggestion:

Hickety pickety my black hen
She lays eggs for gentlemen,
But gentlemen both great and small
Fret about cholesterol.

When I intimated that further exploitation of this concept should be discouraged, he at first demurred, indicating that more might be forthcoming, but apparently he finally conceded that this was not the path to Pulitzer. He did write some fiction that was accepted by *The Saturday Evening Post* and occasionally some supposedly scientific articles, in a popular vein, that went over well with editors. I had a feeling, however, that my friend's tongue must have been thoroughly chewed in his cheek, because I know for a fact that some solemn scientists, bereft of the sort of sounding board available to Quent, and unable to contradict some of his insupportable pontifications in the public press, frothed most productively at their mouths.

In late August 1939, Dalgleish was faltbooting on the Rhine with a fraulein of his own choice and when they came to (this was his phrase on a post card and I assume he meant to the bank of the river) he suddenly discovered there was a war on, and that he was an alien and in trouble. Trifles such as this posed no problem for Quent. Whether by legal means or foul I know not, but in some manner Dalgleish immediately acquired a half dozen trained poodles. He taught them a few new tricks and then toured the countryside, always heading northwest while entertaining the German troops. In one of the acts, the dogs pulled him around in a little two-wheeled cart. One night, by some miscue, they dragged him, of course protesting vehemently, over the border into Denmark. Naturally, just to show off, Quent, with his ideologically oriented animals, had to put on a few performances at Tivoli Gardens.

His own miliary career was somewhat of an anticlimax. When the Inspector General discovered that a particular installation in the Carolinas had an average IQ level seriously lower than that of the Army in general, the issue was dealt with in typical military fashion. A handful of geniuses was transferred to that post to boost this significant statistic to a level acceptable to the Pentagon, and my friend was one of those chosen to serve his flag in this fashion. Ultimately he found himself in a small, isolated African post where he was in far greater danger from flies, mosquitoes, ticks, spiders, belligerent camels, and native girls with ground glass and sharp stones in their hyperkeratotic bare feet, than he would ever have been in an active combat theatre.

IN the decade after the war, Quent finally hit his stride. His most outstanding novel was *Sunday, September Sixth.* The critics were kind to that one and it sold fairly well. I remember Quent saying to me, with a bit of a smirk, that at least he didn't have to worry about the titles for his next 364 novels. What he should have done was stick to the novel but he was bound to write a play. Unlike its characters, *All God's Chillun Got Pox* died a merciful death in New Haven before its inevitable massacre on Broadway.

About then he began writing essays, some of which irritated me to the point whereby, for a while, our relations were slightly cool. He began writing articles dealing with the economics of medicine, about which he knew absolutely nothing. Granted he was in the best of company. Most of the politicians, sociologists, labor leaders, and economists who, at the same time, were sounding off about the distribution of medical care had never so much as distributed a single shot of penicillin into a receptive buttock. Finally, his fascination with this matter faded and the friends of Quent and the friends of Medicine were equally relieved.

One of the facets of his career that I knew little or nothing about was his love life. If this seems incredible to the modern generation, particularly when our relationship appears to have been so close, I can only point out some historical, or perhaps better expressed as sociological, facts. In that distant era, and possibly even trending backward a generation or so, the sexual activity of the human male in ordinary society was customarily thought of as purely a participation sport. It was not even a conversation piece among friends. The role of the avid observer who purchased theatre tickets, or paperbacks, or electronic equipment to add to his total of information on the subject was then much less thoroughly exploited. As a matter of fact, the course was not even being taught as a major in the grade schools. It is difficult to believe that only a few

"more dangerous than active combat."

decades ago we were so benighted in our attitudes that knowledge formerly classified as carnal is now merely filed under the heading "general."

We now approach an incident that has always been an absolute enigma to me. This involves the circumstances surrounding the actual demise of my friend. I have visited the scene, talked to people who were there, and studied the official documents. Yet despite all my inquiries and my most intensive investigations, I have never obtained a satisfactory clinical description of the terminal event. Apparently he was in the best of health shortly before the fatal occurrence. All the evidence I have been able to gather is that Quent was attending a party at Yale, and according to the medical examiner's cryptic report, "He died laughing!"

Naturally I had anticipated that the correspondence and the other data solicited through the *New York Times* would be of great value in obtaining material for my book. I was, therefore, most interested in the results. As is apparent from the following, there were some disconcerting replies.

Dear Jack Hafferstam:

I don't know anything about anybody named Dalgleish but I'm sure glad to have your address after all these years. If the statute of limitations hasn't taken over there will be a bill collector around tomorrow.

(Signed) Mrs. Dottie Schulz
(your former landlady)
139 St. Botolph St.
Boston, Mass.

Dear Mr. (sorry)
Dr. Hafferstam:

It was my rare privilege to know Cue Dalgleish (as we knew him then) as a boy and as a young man. I mean *he* was a boy and a young man. He was born and raised right here in Scott's Ferry and if I do say so he was my first love. I remember so well. It was the first time he was ever close to me. I was in the kitchen at home and I was putting acne lotion on my face and I remember he came in and smiled at me and said, "My, something smells good around here!" Then he spotted the pan of molasses cookies my mother had just taken out of the oven, and when the cookies were all gone I had taken off the lotion and he had taken off. He left Scott's Ferry when he was seventeen.

(Miss) Theresa Muckenfuss

Dear Dr. Hafferstam:

Cue Dalgleish was without doubt one of our favorite people around here in Scott's Ferry. All the kids and the stray dogs loved him, but he was par-

ticularly fond of my Uncle Jasper. That was a little strange because no one else in the village thought too well of my Uncle Jasper. In fact he was the village bum. The minister remarked that Jasper looked upon the wine when it was red, but most of the congregation had a less charitable approach. Anyway Cue seemed to be good friends with Uncle Jasper and it was apparent that the two had something in common. Anyway when Cue left Scott's Ferry at the age of 17 he left a will, drawn up and properly witnessed in which he left to my uncle "my coin collection housed in the blue and yellow porcine receptacle, and the black walnut box with its contents." A couple of years ago when Uncle Jasper came into his inheritance and finally opened the blue and yellow piggy bank he discovered that it contained U.S. coins, pennies, nickels and dimes with a face value of $7.69. The legacy was ultimately appraised at $7.69. "That's one good thing about U.S. currency," said my Uncle Jasper, "only the purchasing power declines." The black walnut box, on the other hand, contained several documents neatly arranged and stacked. There were twenty S & H green stamps, his high school diploma, a newspaper clipping of a biography of Robert LaFollette, and an autographed picture of Lefty Grove. Needless to say my uncle was touched.

Most sincerely,
Hyacinth Dalgleish O'Toole

Dear Dr. Hafferstam:

I certainly do remember that nut. I knew him in the early days of the Model "A" Ford. The radiator cap and the gas cap looked alike and were interchangeable as far as the threads were concerned. However the gas cap had a pin-hole in it to let air in the tank, but the radiator cap had no need for such. If you switched and put the radiator cap on the gas tank, pretty soon as you drove, a vacuum would be created and you would think you were out of gas. You get out, take off the cap, look in the tank, measure the gas with a stick, there is plenty of gas, you put the cap back on, start her up, and because now the pressure is restored you chug along a few miles until the same thing happens again. If you don't know what it is all about it can be very confusing. That damned pinhead Dalgleish did that to me when I was starting on my first honeymoon.

Sincerely,
Manville Thomas

Dear Dr. Hafferstam:

You asked for memorabilia. Here is a box of Christmas cards from the late thirties with the names Zelda and Quent Dalgleish printed on them. No charge except that I am sending them collect.

Best wishes,
Zelda Lynch Dalgleish
Pierce Fenner Smith

Dear Dr. Hafferstam:

One summer back in the late forties there was a writer who rented a cabin from us here in Friendship, Maine. He used to bang away at a typewriter all day long. My daughter was 18 that year and she would sometimes go down and cook him a mess of vittles. I was always a little bit concerned but she would say, "Why, Maw! he's really in earnest. He tells me his name is Hemingway and he's a famous author. I can learn a lot from him." She learned a lot I guess, but Hemingway must have been his pen name. He always signed his checks Dalgleish.

(Mrs.) Perley Gately

By the time I gathered all this data and perused it carefully, I began to have some serious second thoughts about the need for, and the value of, a definitive biography of my late friend. Could it be that because of my contiguity, so to speak, to a minor literary figure I had been overly impressed with his importance? Would it be better to allow the passage of time — say a hundred years — to assay Quent's contribution to *belles lettres* and the contemporary scene. Suddenly I began to wonder if perhaps, instead of writing a biography of my hero, my efforts might be more profitably spent in composing his epitaph. This, indubitably, will require a great deal of thought.

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Proper Bostonian Botanist

by George E. Gifford, Jr., M.D.

A BRASS PLAQUE in the front lobby of the Boston Museum of Science, a unique mushroom with gills that run in concentric circles instead of radially, and a genus of rubiaceous (madder) plants in India all honor a shy, wealthy, proper Bostonian who was both a physician and lawyer by training, but who directed his capital and energies to support botany. Benjamin D. Greene, M.D., (1793-1862) was a perfect example of the gentleman amateur who was to interject a trickle of hard cold cash into the barter economy that characterized botanical exchange.

His father, Gardiner Greene, conducted business in Demerara, British Guiana, returned to Boston, and became president of the Boston Branch of the United States Bank. He was reputed to be the wealthiest citizen of his time. Dr. Greene's mother — the third wife of Gardiner Greene — was Elizabeth Clarke, daughter of the great Boston painter, John Singleton Copley.

If Boston was the "Athens of America," then the Greene estate must have been the Acropolis. It was situated on the crest of a hill, later known as Pemberton Square. The house has been described as "the most splendid private residence in the city" and was especially known for its gardens. One account reads, "The most extensive and highly embellished garden of this locality was that of Gardiner Greene in which he had one of the first greenhouses in Boston and cultivated in the open air the Black Hamburg and Chasselas grapes, peaches, apricots, nectarines, and also plums and a great variety of pears. The entire grounds were adorned by both nature and art." The estate commanded an extensive view of the harbor and its headlands; the terraced grounds displayed a great diversity of plants both fruit and ornamental. Soon after Greene's death in 1832, a building development completely obliterated the estate, but through the efforts of the good Dr. Jacob Bigelow, Professor of Materia Medica at Harvard Medical School, a gingko tree from it was successfully transplanted to the nearby Boston Common.

Benjamin Greene was born in Demerara in 1793 while his parents were temporarily living there. He was a member of the Harvard College Class of 1812 where he came under the influence of William Dandridge Peck, the "Massachusetts Professor of Natural History." After graduation, he pursued botany with continuous enthusiasm. There is a record of his staying at Crawford's Inn, near Mt. Washington, New Hampshire, and, with a friend, of his going up the Crawford Path on the southwestern ridge and staying three days on the "Alps." Their botanizing was most successful: Greene found an extremely rare alpine moss and a far northern honeysuckle. But botany was not all. He studied law at Litchfield, Connecticut, and was admitted to the Boston bar.

GREENE's medical experience in Great Britain was the most significant event in his life. He studied at London and Edinburgh and received his M.D. from Edinburgh in 1821. It was there he met the great William Jackson Hooker (1785-1865). At that time (1820) Hooker was the Regis Professor of Botany at Glasgow University. The Hooker herbarium was world renown, and even while his work was in progress, he received large and valuable additions from all over the globe. As Director of the Royal Botanic Gardens at Kew (1841), he became the most important figure in botany in the English-speaking world.

> Not only as one of the able scientists and botanical teachers of Great Britain but as the organizer of a major project in North American exploration, Hooker was the connecting link between the best of Old World science and the brightest of New World hopes. His collectors had ranged to the farthest outposts of the Hudson's Bay Company, bringing back plants for a *Flora Boreali-Americana,* of which the first part was nearly through the press in 1833.

Back in the United States, Greene also took on a distinct advantage. His wife, Margaret Morton (Quincey), was the fourth of the five "articulate daughters" of Harvard's President, Josiah Quincey. Greene assisted Thomas Nuttall who was the Professor of Natural History at Harvard (1822-1834), and President Quincey, who was inaugurated in 1829, "seemed to have sympathized with Nuttall's ambitions to carry on field investigations and was generous in endorsing leaves of absence for him." Nuttall was a frequent guest at Greene's home and is often mentioned in his letters to other botanists. Certainly Greene would have encouraged his father-in-law to support Nuttall's botanical endeavors.

The Boston Society of Natural History, which was organized during during the first half of 1830 by a remanent of the New England Linnean Society, elected Thomas Nuttall as its first president. However, he declined the honor on the plea that he was only a transient resident in the Boston area. In August of that year, perhaps with characteristic Bostonian thought of future benefactions, the membership chose Benjamin D. Greene in his stead. Certainly Greene could match those who were capable of supporting natural history with those who needed support. Audubon wrote:

> I dined with Dr. B. D. Green [e], President Quincey, Isaac P. David and Mr. Nuttall. In the evening Dr. Shattuck finished the subscription list of the society by presenting me to his lady who subscribed for one-tenth, and the Dr. then put down his son George's name for one-twentieth, making his own family one-fourth of the whole, or two hundred and twenty dollars, for which he gave me his check. Without the assistance of this generous man, it is more than probable that the society never would have had a copy of the *Birds of America.*

Greene's catalytic activities were also partially responsible for bringing Asa Gray — destined to become the leader of American botany — to Harvard. As early as 1833, plants collected by Gray "went to B. D. Greene and his brother Copley." A friendship began and grew because both were close to Sir William Hooker. In 1837 Gray had become a corresponding member of the Boston Society of Natural History and his European trip had brought him into contact with Francis Boott, an old friend of Greene's. Gray was also in regular correspondence with

William Oakes of Ipswich. These scattered, but increasing connections with Boston people culminated in the fall of 1841 when Gray was elected to the American Academy of Arts and Sciences. Thus, Asa Gray was early recognized as one of the country's leading botanists. In 1833 Dr. Joshua Fisher of Beverly, Massachusetts, left $20,000 for a professorship of natural history and the chair was offered to Francis Boott, the botanist and physician. Gray heard of this and inquired about the position in a letter to Greene.

Greene was the right man to consult since he immediately inquired of his father-in-law, President Quincey, and Greene cordially suggested that Gray visit Boston. Gray came to Boston, stayed at Greene's home, passed the test, and was offered the professorship. It marked the first time a full-time botanist who could carry on research became a member of the faculty at an American college.

Greene was honored by his fellow botanists in the usual botanical manner — plants were named for him. After a western trip, Thomas Nuttall honored only one person by naming a genus of grasses for Greene, *Greenia Arkansana*, but as Wight and Arnott had already published an Indian shrub as *Greenea*, the modest American grass could not bear his name; it became *Limnodea Arkansana* (Nutt.). On his death, Greene's sister-in-law, Mrs. Waterston, wrote, "To please a wish of my own heart there was cut on the marble the grass which was named for Mr. Greene, by Thos. Nuttall, when he discovered it on the Western Plains, the Greenia Arkansia." Apparently the stone was changed — since the monument in Mt. Auburn cemetery today does not have a grass on it.

In 1845 there appeared in *Hooker's Journal of Botany* a description of a new mushroom, *Cyclomyces Greeneii* by Berkeley. The original specimen was sent to Hooker by Greene from Tewksbury, Massachusetts. Many of Greene's specimens are at Kew in Hooker's collection.

At his death, Greene willed his botanical books, his herbarium, and a legacy of $9,000 to the Boston Society of Natural History. This Society has become the Boston Museum of Science. Two brass plaques in the entrance bear Greene's name; one lists him as a benefactor and another is a tribute to the founders of the Boston Society of Natural History. It reads, "This museum is a living memorial to their spiritual greatness and pioneering vision."

Greene's great service was to endow the developing natural history movement, and he did it with the skill and wisdom of a proper Bostonian Botanist.

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"He Plants His Footsteps in the Sea"

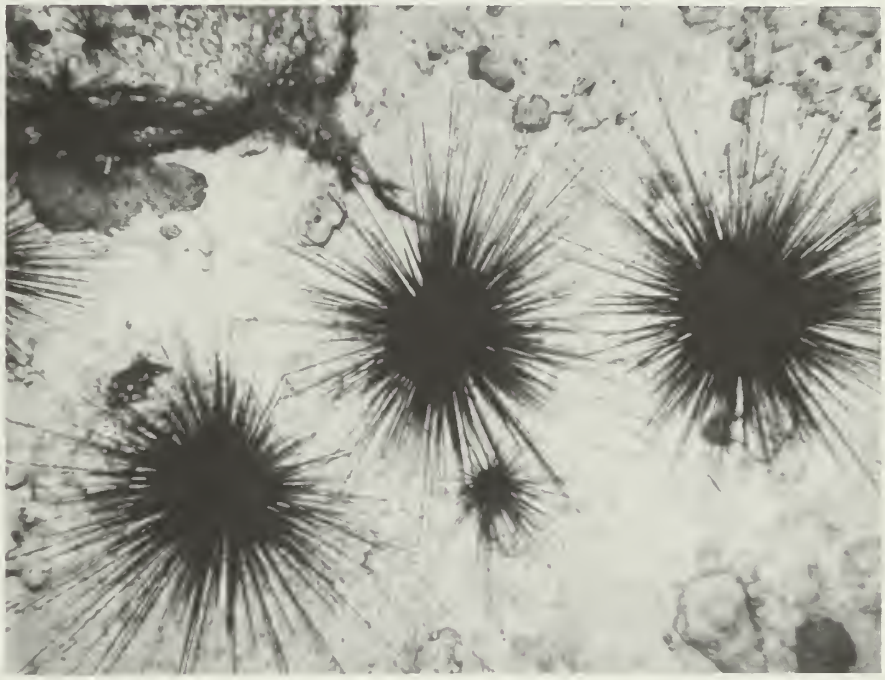
Six years ago, S. Harold Reuter '59 rented a glass-bottomed boat — and changed his life. While vacationing in Jamaica, he saw the intricate beauty of the deep for the first time. And he, like Jules Verne and Jacques Cousteau, was captivated.

On his return to his native Houston, he enrolled in a diving course and became certified. Today, he is one of the world's foremost authorities on the medical aspects of scuba (**S**elf-**C**ontained **U**nderwater **B**reathing **A**pparatus) diving and, as can be seen from these pages, an international, award-winning photographer.

As a practicing otorhinolaryngologist and clinical instructor in the department of otolaryngology at Baylor College of Medicine and at the University of Texas Medical Branch at Houston, it is not surprising that Dr. Reuter became interested in the medical aspects of diving. "The most common problems encountered by divers," he said, "are infections of the skin of the external ear canal, commonly known as 'swimmer's ear,' and pressure changes in the middle ear."

Another common diving problem — the bends — has an interesting history. The word derives from the 17th century, when women wore corsets so tight that they were forced to walk in a bent position. At about the same time, the first caissons (pressurized, water-tight compartments used in the construction of tunnels) were being built. If workers "rose" too quickly, without undergoing decompression, they would develop joint pain, and, like the tight-corseted ladies, could not walk in an upright position. Hence, the bends.

In diving, the bends, or decompression sickness, also result from coming to the surface too quickly, and can range from simple joint pain to permanent spinal cord damage causing paralysis of the legs, and even death. Therefore, the most important thing divers must calculate is how deep to dive, and how long to stay at that depth.



Sea Spine Urchins

The diving tables used for this calculation are complicated and difficult to read. As a matter of fact, three separate tables must be read in order to determine the length of time a diver may stay at a specified depth without having to decompress during ascent.

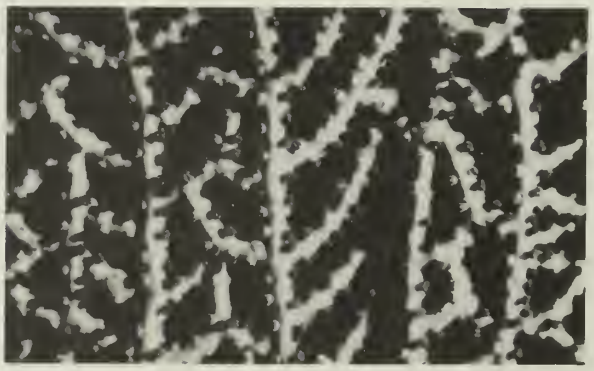
One of Dr. Reuter's significant contributions to the world of diving is his revision of these dive tables. Actually, he is the first to admit that all he did was take the available information and re-organize it.

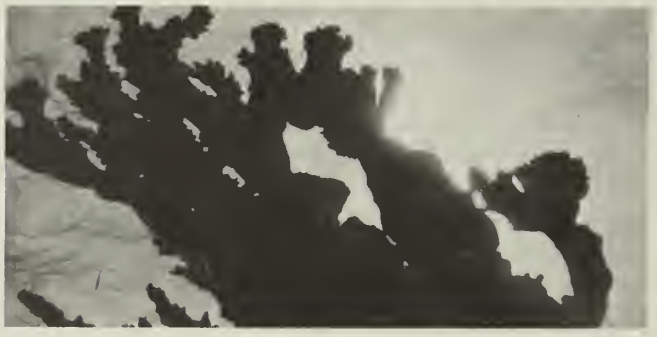
But his re-organization amounts to a revolution because, after having decided to what depth the diver wishes to go, he simply follows an arrow on the chart, and in seconds, can determine his safe time limit at that depth.

In an equally revolutionary manner, Dr. Reuter has contributed to the medical profession. He is the inventor of the Reuter "Bobbin" Tube for long-term ventilation of the middle ear, and more recently of the Reuter Bivalve Teflon® Nasal Septal Splint and the Reuter Septal Suture Clamp for use following a submucous resection or rhinoplasty.

The photographs on these pages represent a mere fraction of those taken by Dr. Reuter over the years, and belie the fact that he is classified as an amateur. He has won numerous trophies in worldwide photographic competitions, including a Gold Medal and "Best of Show" (for *Black Angel Fish*), and a Bronze Medal (for *Labyrinth*) at the Ninth Annual International Underwater Photographic Exposition. He is particularly proud of being awarded Gold (for *Les Plumes*), Silver (for *Bluebells*), and Bronze (for *Featherdusters)* medals in the Underwater Society of America's elimination competition restricted to entries which have previously won other contests. Dr. Reuter also received the "Silver Sea Star" in the Italian *Mondo Sommerso* International competition (for *Christmas Under Water*).

Continued on page 36 . . .





Beginning above and moving clockwise: Jellyfish; Tunicates on soft coral; Staghorn Coral; Fan Coral: Plume Worms or Feather Dusters; Sea Anemone; "Labyrinth" (Leaf Coral); and "Seaswept" (Butterfly Fish, Sponge, and Whip Coral).

Beginning at right and moving clockwise: Dr. Reuter introducing his "No-Calculation" Linear Dive Tables for Repetitive Scuba Diving at the Third International Conference on Underwater Education; "Tortuga"; Underwater Photographer in Action; Tubular Cone Worms; Squirrel Fish; Puffer Fish; Black Angel Fish; and "Fireworks" (Coral Polyps).

Alumni NOTES

1907

Richard M. Smith writes: "Still living and well. Miss my contemporaries but have many younger friends whom I enjoy seeing."

1909

Donald Macomber writes: "My only claim to fame is that I now have ten great-grandchildren with the eleventh on the way!"

1913

Ralph A. Goodwin, Jr., writes: "I am still in active practice."

1915

Stanley Boller reports: "No interesting news, having been retired since 1956. My wife died one month ago after suffering with arthritis for several years; a very trying experience. We would have been married 60 years next July."

Kenneth L. Dole and his wife celebrated their golden wedding anniversary in Palo Alto in August '71. All of their children, grandchildren, and spouses were present, numbering 17 in all.

1918

Leland S. McKittrick retired on July 1, 1971 and is living an active but restful life in Jaffrey, N.H., but spends his winters back in Boston.

1920

Edward D. Churchill announces the publication of his book *Surgeons to Soldiers* by J. B. Lippincott Co. The book recounts his experiences in World War II.

Lawrence W. Smith has prepared for his retirement at 80 years by moving to the Adult Condominium Village (no one under 55 allowed) where most of the unpleasant chores such as snow shoveling and grass cutting are left up to the Association. He is still active in diagnostic clinical laboratory practice.

1921

Paul B. Shuey writes the *Bulletin:* "Russia for the month of August with a congenial group of Harvard alumni, was a delightful experience.

Our daughter Virginia joined us in Amsterdam on our way to Moscow where she presented an all Russian concert three years ago in the University of Moscow.

Then to Leningrad — Russia's "Venice of the Earth." Looking out from our 6th floor window is the magnificent Leningrad Hotel. The early morning sunlight strikes the golden spires and star spangled doors of the many churches across the Neva. The sleek white hydrofoils streak past the cruiser Aurora anchored opposite our hotel. The Hermitage, filled with the finest art that Catherine and Peter the Great could lay their hands on, including 26 Rembrandts — required more hours than we could spare.

Every hour was carefully planned including two ceremonies in the Castle of Weddings. Then the Museum of Peter and Paul Fortress. Driving through the country past mile after mile of fruit laden trees to Pushkin Park and Museum. Then to Lagorsk — a beautiful sequestered town, where religious services were held in a beautiful silver starred, blue domed church set in banks of multicolored flowers. On to Kiev, a huge, industrial exhibit. In the evening Verdi's opera Romeo and Juliet was performed in Russian.

Finally Moscow-St. Basil and Lenin's Museum and Tomb. Topped it off in a farewell dinner and dance at a great Moscow ballroom and cabaret."

Clark Young writes: "What a thrill to meet with the classmates of 1921 in June. Our 50th anniversary! Who ever imagined back in '21 that it would ever roll around? 54 still living, 49 deceased; 2, Hu and Tsaing unaccounted for in my year book. Pretty good considering most of us are about 76. Around 25 attended, only 21 for the picture. I will say life seems to have dealt very well with most of us. Let's ALL get together in 1976. My thanks to Bill and Louise Castle who did so much to immortalize in my memory my visit. Also to the remarkable Kazanjians. Carry on mates!"

1922

Leo M. Davidoff has retired from practice and is fighting Parkinsonism with L-dopa and other weapons.

Hallowell Davis is emeritus professor but not retired. He still does clinical work and has an EEG laboratory. He teaches a little and "loves it all."

Ralph C. McLeod writes: "Nothing usual, continuing in general surgery."

1923

After he resigned as Kansas City Police Surgeon and discontinued his private practice **Harvey C. Lapp** organized and directed a Multiphasic Diagnostic Laboratory at the Jackson County Public Hospital. He saw the project develop from zero to 600 cases a month the first year and became a smoothly running operation. Dr. Lapp has now retired completely and is getting ready to attend the 50th class reunion in 1973.

1924

Raymond J. Reitzel writes: "Meeting Perry J. Culver '41 and President Bok in San Francisco was the most enlightening event of all time for alumni meetings."

1926

Charles R. Baisley is still in limited practice as an internist. He is no longer practicing obstetrics or surgery.

G. Curtis Crump retired from Veterans Administration Hospital on Dec. 1, 1971 but continues on in special assignments on a yearly basis.

1927

Harold J. Freedman writes that: "Am happy to report that I am still active at Wentworth Institute, Boston Health Department, and private practice. This is the only way I can say hello to all my classmates." Signed: Mickey.